ATTACHMENT 1

Integrated Plan Format Guidance

This integrated plan format was developed by the
AIDSNET Coordinator's to increase the uniformity
of regional plans and facilitate the inclusion of
all elements of the planning process

Region Z AIDS Service Network

200x-200y Region Z Comprehensive HIV Prevention Plan

CONTENTS

200x-200y Region Z Comprehensive HIV Prevention Plan

A. EXECUTIVE SUMMARY

Provide a brief (no more than one page) summary of the priorities and plans for the years covered by the planning document.

B. INTRODUCTION

Provide a brief discussion of the history of community planning and the planning group in your region. Indicate major changes in the process since it began and how that has impacted the process. Discuss any important issues that preceded the planning process that resulted in this plan. (Please limit this discussion to no more than 2 pages.)

CDC CORE OBJECTIVE #1

Fostering the openness and participatory nature of the community planning process.

CDC CORE OBJECTIVE #2

Ensuring that the community planning group(s) reflects the diversity of the epidemic in the jurisdiction, and that experts in epidemiology, behavioral science, health planning and evaluation are included in the process.

C. MEMBERSHIP AND PIR

Using information gathered through a confidential/anonymous membership profile survey process, provide the following information:

MEMBER PROFILE DATA COMPARISON – AS OF _____(Date)
(Please record planning group information by number/percent)

		Planning Group	Epi Profile Data	Other data (1)	Regional Demographics (2)
AGE:	</= 19				
	20-24				
	25-29				
	30-49				
	50 and over				
GENDER:	Male				
	Female				
	Transgender				
SEXUAL	Homosexual				
ORIENTATION:	Bisexual				
	Heterosexual				
	Unknown				
GEOGRAPHIC	Urban				
LOCATION:	Mid-size (<100,000)				
	Rural (<2,500)				
ETHNICITY:	Hispanic/Latino				
	Not Hispanic/Latino				

RACE:	American Indian/ Alaskan Native				
	Asian				
	Black/African Amer				
	Native Hawaiian/ Pacific Islander				
	White				
	More than one race				
HIV RISK	MSM				
CATEGORY	IDU				
	MSM/IDU				
	Heterosexual at risk				
	General Population				
TOTAL NUMBER OF MEMBERS* **					

(1) Please indicate the source of the comparative data
(2) Reported demographic/census data
(3) Please indicate the total number of members used to determine the percentages in this table

PLANNING GROUP MEMBERSHIP BY GOVERNMENTAL AND NON-GOVERNMENTAL REPRESENTATION

PRIMARY REPRESENTATION	**Number of Members**
MEMBERS FROM GOVERNMENTAL AGENCIES	
State Health Department	
Local Health Department(s)	
Education Agencies	
Correction Agencies	
Mental Health Agencies	
Substance Abuse Agencies	
Youth Agencies	
Other Governmental Agencies	
Total Government Members-Primary	
NON-GOVERNMENTAL MEMBERS	
Community-based Organization -Non-minority Board	
Community-based Organization – Minority Board	
Faith Organization	
Academic Institutions	
Research Center	
Other Non-Profit	
Individual person representing _____	
Other _____	
Total Non-Governmental Members-Primary	
SECONDARY REPRESENTATION	
MEMBERS FROM GOVERNMENTAL AGENCIES	
State Health Department	
Local Health Department(s)	
Education Agencies	

Correction Agencies	
Mental Health Agencies	
Substance Abuse Agencies	
Youth Agencies	
Other Governmental Agencies	
Total Government Members - Secondary	
NON-GOVERNMENTAL MEMBERS	
Community-based Organization -Non-minority Board	
Community-based Organization – Minority Board	
Faith Organization	
Academic Institutions	
Research Center	
Other Non-Profit	
Individual person representing _____	
Other _____	
Total Non-Governmental Members-Secondary	
PRIMARY EXPERTISE CATEGORY	
Epidemiologist	
Behavioral/Social Scientist	
Health Planner	
Evaluation Researcher	
Intervention Specialist	
Community Representative	
Other _____	
Total Members/Expertise (must equal total membership)	
SECONDARY EXPERTISE CATEGORY	
Epidemiologist	
Behavioral/Social Scientist	
Health Planner	
Evaluation Researcher	
Intervention Specialist	
Community Representative	
Other _____	

Please include a list of Planning Group Members as Attachment 1.

Has the Planning Group developed a PIR Plan? YES NO

If yes, include the plan as *Attachment 2* of the comprehensive plan.

If no, what is the process and timeline for development and implementation of a PIR Plan?

Does the plan address all the elements in the PIR Plan Guidance? YES NO

If no, please discuss what the issues and missing elements are and how the planning group will resolve them.

Please answer the following questions:

1. What progress has been made in implementing the PIR Plan? What have been the successes and shortfalls? What barriers to implementing the PIR plan have been identified? What actions have been planned to overcome these barriers?

2. How does the planning group solicit public input for the planning process? How does the planning group assure that the public is aware of the meetings and the planning process? Please include a brief discussion of how successful this public input process has been and if the planning group has formulated any changes.

   Does the planning process reflect solicitation of community input at meeting on in some other manner?

3. How does the planning group assure that all meetings are accessible and accommodation is provided?

   Are meetings accessible and is accommodation provided?

4. Is there additional information needed to characterize you planning group's quality of meeting the intent of CDC CORE OBJECTIVES 1 and 2?

   Do the demographics reported in the planning group membership summary reflect:
   a. geographic distribution (i.e. counties, cities, towns, etc)
   b. the Epidemiologic Profile
   c. Other indicated demographic or surrogate markers (what?)

   Does the planning group membership include experts in appropriate disciplines, including epidemiology, behavioral science, health planning and evaluation?

   Does the planning group membership reflect the age, gender, race/ethnicity, socioeconomic status and identified at-risk populations indicated in the epidemiologic profile and other demographic indicators?

D. MEETING INFORMATION

Please include a calendar of the planning group meetings and the minutes for any meeting where binding decisions were made. This may include only the full planning group meetings, or may require inclusion of relevant sub-group or sub-committee minutes. This is *Attachment 3* of the Plan.

E. PRIORITIZATION OF RISK TRANSMISSION CATEGORIES AND SUB-CATEGORIES

CDC CORE OBJECTIVE #3

Ensuring that priority HIV prevention needs are determined based on an epidemiologic profile and needs assessment.

Features identified for evaluating the community planning process (nation-wide):

A. PRIORITY SETTING

A1. Priority Setting: Target Populations

Evidence that all of the following factors were considered in a systematic fashion when prioritizing risk populations

Some *systematic approaches* include (not an exhaustive list)

- a weighed variable approach
- a cost benefit analysis
- an epi-mapping approach
- consensus
- modified consensus
- consensus/voting
- voting
- formula

134. (N) size of at-risk population
135. (N) HIV seroprevalence, if available
136. (N) Prevalence of risky behavior in the population
137. (N) Extent of **CDC** resources currently targeting the population
138. (E) Extent of **non-CDC** resources currently targeting the population
139. (E) Multiple high risk populations within the target population defined by demographics and/or behavioral factors (e.g. African American pregnant women who may be HIV infected; young IDU; young MSM who are having UAI)
140. (E) Difficulty of meeting need
141. (E) Emerging issues (trends in the epi or issues for which limited data are available)
142. (N) Clear statement describing why each high priority population was chosen (may include finding in epi profile)

Populations

143. (N) Populations are prioritized/ranked by risk
144. (N) Populations are ***behaviorally*** risk based (vs. identity based) (the reason the population is identified is based on actual known behaviors or potential for behaviors that put them at risk for transmission. May be subdivided by other demographic characteristics, e.g. MSM under the age of 24 who participate in UAI; African American women who are sex partners of heterosexually identified MSM or needle sharing men. General population is NOT a risk-based population
145. (N) other characteristics routinely described (e.g. geographic or demographic characteristics)

(I think we can summarize the above features, perhaps in a table? Let me think about this please.)

Did the planning group prioritize the risk transmission categories? YES NO

If yes, list the categories in descending priority.
If no, explain.

Did the planning group prioritize the sub-categories or populations? YES NO

If yes, list the sub-categories/populations in descending priority.
If no, explain how determination of priorities was or will be made.

Did the planning group use the Decision-Making Model Guidance from the SPG for the prioritization process? YES NO

If yes, include the guidance worksheets as *Attachment 4.*
If you made any changes to the guidance process, please detail those changes and explain, in *Attachment 4.*

If no, did the planning group use another model? If so, please detail the model and include as *Attachment 4.*

Are the results of the prioritization process consistent with the relevant data? With the method used?

Were any needs assessment(s) completed? If so, were they reflected in the prioritization process? (Gap Analysis)

F. PRIORITIZATION OF EFFECTIVE INTERVENTIONS

CDC CORE OBJECTIVE #4:

Ensuring that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values.

Features identified for evaluating the community planning process (nation-wide):

A2. Priority Setting: Interventions

Evidence that all of the following factors were considered in a systematic fashion when prioritizing interventions

146. (N) Demonstrated application of existing behavioral and social science evidence (including evaluation data when available) to show effectiveness in averting or reducing high-risk behavior within the target population
147. (N) Evidence that intervention is acceptable to target population (in keeping with norms and values)

148. (N) Evidence that the intervention is feasible to implement for its intended population and in its intended setting
149. (N) Evidence that intervention was developed by or with input from the target population (may be part of the literature)
150. (E) Evidence that the availability of other governmental and non-governmental resources (including private sector) for HIV prevention interventions was considered in a systematic way
151. (E) Evidence that the intervention is cost effective
152. (E) Evidence that the intervention is sustainable over time
153. omit
154. (E) Clear statement describing why each intervention was chosen

A3. Priority Setting: Scientific Evidence for Interventions
Evidence of the application of knowledge from existing behavioral and social science/evidence to show effectiveness in averting or reducing high-risk behavior within the target population. The proposed intervention has:

155. (N) undergone previous evaluation in current setting
156. (N) been implemented in *similar* context (setting and population) and evaluated by others
157. (N) been implemented in *different* context (setting or population) and evaluated by others
158. (N) applied formal theory in program development
159. (N) applied informal theory in program development
160. (N) used another type of scientific evidence

Interventions

161. (N) prioritized/rank by risk population
162. (N) inclusion of *general* description of proposed interventions
163. (N) inclusion of *general* description of existing intervention
164. (E) inclusion of *specific* definitions, characteristics or criteria for each type of proposed and existing intervention (i.e. the CP says MORE than 'do individual levl interventions for MSM')
165. (E) inclusion of *specific* descriptions of proposed interventions
166. (E) inclusion of *specific* description of existing interventions
167. (E) inclusion of intervention strategies beyond those which health department funds might support (i.e. needle exchange is not funded through federal dollars, but funding is secured from other sources)
168. (E) Inclusion of specific cultural, social or political factos that could impact the strategies suggested by communities
169. (N) Explicit demonstration of linkages between the comprehensive plan and the application for CDC funding (e.g. budget information on Intervention Plans)
170. (N) Explicit demonstration of linkages between the comprehensive plan and funded interventions
171. (E) Evidence of the linkages between the needs assessment, resource inventory and gap analysis in the development of the comprehensive plan

(I think, again that we need to summarize this section of features....Let me work on it tomorrow.)

Did the planning group prioritize the effective interventions for the prioritized risk behavior categories/sub-categories or populations? YES NO

If yes, list the prioritized effective interventions for each category/subcategory or population in descending order.
If no, please discuss how the planning group determined or will determine the effective interventions to be used to impact the prioritized category/subcategory or population.

Did the prioritization of interventions include behavioral science and outcome effectiveness information?

Please attach the following documents:

Attachment 5: Epidemiologic Profile
Attachment 6: Community Resource Inventory (CRI)
Attachment 7: Intervention Plans for all CDC funded activities.

G. GAP ANALYSIS

Has the planning group developed a gap analysis and plan, in accordance with SPG guidance, to address the identified gaps?

If yes, include summary sheet here; and worksheets as *Attachment 8*.
If no, has a timeline and plan been established to do so?

Were gaps in interventions or services identified and prioritized?

Was there a plan or discussion of how these gaps might to addressed or reduced?

If the planning group utilized a method other than the SPG Guidance to develop the Gap Analysis, please summarize the identified gaps in the plan here. Provide the details of this method as *Attachment 8.*

Features identified for evaluating the community planning process (nation-wide):

D. GAP ANALYSIS

172. (N) The GA addresses each of the risk populations identified in the EP
GA includes data from the following sources:
173. (N) Epidemiologic Profile
174. (N) Needs Assessment
175. (N) Resource Inventory
176. (N) The GA specifically identifies both met and unmet needs
177. (N) The GA identifies the portion of *met* needs
178. (N) The GA addresses availability or accessibility of (or barriers to) existing services
179. (E) The GA provides an estimate of needs for each target population including both programmatic and fiscal needs
180. (E) Upon completion of the GA, the CPG was provided with a summary of the findings

H. COST ANALYSIS

Has the planning group completed a cost effectiveness analysis of the prevention interventions, as outlined in the SPG Cost Effectiveness Guidance?

If yes, summarize the results in the plan and include the worksheets as *Attachment 9.* If no, have any plans for cost effectiveness analysis been made? Please detail.

If the planning group utilized a different method the cost effectiveness analysis in making these determinations, detail the method as *Attachment 9.*

Was cost analysis included in the consideration? If yes, how?

I. LINKAGES OF PRIMARY HIV PREVENTION AND CARE SERVICES

CDC CORE OBJECTIVE #5:

Fostering strong, logical linkages between the community planning process, plans, applications for funding and allocation of CDC HIV prevention resources (and, in Washington, 50% of the Omnibus funding).

Please discuss how the planning process and subsequent interventions are linked with secondary and support HIV services within the planning jurisdiction. Are there linkages with HIV/AIDS care planning or services, other medical services or interventions, and/or other health related prevention efforts?

Do the allocations of resources reflect the plan priorities for populations and interventions (foster strong logical links between community planning process and allocation of 100% of the CDC funds and 50% of the Omnibus funds)?

Are 100% of the CDC and 50% of the Omnibus resource allocations targeting the priorities established in the regional plan?

J. COORDINATION WITH STD, TB, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

Please discuss how the planning process and subsequent interventions are coordinated with STD, TB, Substance Abuse, Ryan White and Mental Health services within the planning jurisdiction.

STD (STI) Services?

TB Services?

Mental Health?

Substance Abuse?

Ryan White?

K. COORDINATION/COLLABORATION BETWEEN GOVERNMENTAL AND NON-GOVERNMENTAL PROGRAMS

Please discuss any coordination/collaborations between governmental and non-governmental programs within the planning jurisdiction that support, enhance or facilitate HIV prevention efforts.

Other CDC or non-governmental HIV/AIDS efforts in the region?

L. ASSESSMENTS

Has the planning group completed any Target Population Assessments? YES NO

If yes, please include a summary of the activities and findings in the plan; and provide the assessment reports as *Attachment 10*.

If no, are there plans to do so and what are they?

Features identified for evaluating the community planning process (nation-wide):

B. NEEDS ASSESSMENT

98. (N) Needs assessments focus on population identified in the EP
99. (N) Extent to which decisions about the data that are needed are determined jointly by CPG members and health department staff
100. (N) Evidence of explicit roles and responsibilities of HD staff, CPG members and external consultants in conducting Needs Assessments is documented
101. (N) Extent to which distribution of funds for needs assessments is determined with input from CPG members and health department staff.
102. (E) Data are gathered that define populations' needs in terms of knowledge, skills, attitudes, norms and access to services (KABB)
103. (E) Multiple data collection methods were used to conduct needs assessments, e.g. qualitative and quantitative

Prior to the execution of the NA, the CPG was provided with the following information about the NA:

104.(N) Purpose and objectives (desired outcomes, scope)
105.(N) Research questions
106.(N) Populations of specific focus
107.(N) Data collection and analysis methods
108.(N) Time line/Work Plan
109.(N) NA are current and meet the decision-making needs of the CPG
110 (E) Upon completion of the NA, the CPG was provided with a summary of the findings

M. TECHNICAL ASSISTANCE AND SUPPORT FOR HIV PREVENTION

Has the planning group identified areas in which technical assistance is needed?

If yes, please detail these areas and what action the planning group feels would best meet these technical assistance needs.

Does the plan include requests for or reports on technical assistance needed or received?

Are there other issues or areas of concern that have been identified by the planning group? Have solutions or approaches to solutions been formulated?

N. COMMUNITY PLANNING EVALUATION

Has the planning group developed a Community Planning Evaluation Plan? YES NO

If yes, please include as *Attachment 11.*
If no, what are the anticipated timelines for developing the CP Evaluation Plan?

A community planning evaluation plan? Has it been addressed this year? How will the findings effect next year?

Were there any other evaluations of either the planning process or services indicated in the plan? If so, what?

Please summarize any community planning evaluation findings for this planning year.

O. OTHER EVALUATION ACTIVITIES

Has the planning group developed an Outcome Evaluation Plan? YES NO

If yes, please include as *Attachment 12.*
If no, what are the anticipated timelines for developing the Outcome Evaluation Plan?

Please summarize any outcome evaluation findings for this planning year.

P. PROGRESS REPORT

Please briefly discuss progress in implementation of the previous year's plan. What worked, what did not work? Discuss any changes in this year's plan that reflect these findings.

Indicate the successful prevention efforts in the region and areas of concern?

Were these concerns addressed in the Prevention Plan?

Q. LETTER OF CONCURRENCE/NON-CONCURRENCE

Please provide a brief summary of the process for determining whether a letter of concurrence will be approved by the planning group. What will be the consequences and resolution for a letter of non-concurrence? When will the final letter be issued by the planning group? (If available, please include as *Attachment 13: Letter of Concurrence/Non-Concurrence).*

Is there a letter of Concurrence or Non-Concurrence? Issues?

ATTACHMENT 1: LIST OF PLANNING GROUP MEMBERS

Insert your documents/text here by cutting and pasting over these RED instructions..

ATTACHMENT 2: PIR PLAN

Insert your documents/text here by cutting and pasting over these RED instructions. Attach a copy of your RPG's PIR Plan if you developed one.

Does the PIR plan discuss methods used for recruitment, retention and utilization of planning group members? How?

Does the PIR Plan identify the PIR needs of the planning group? What are they?

Are the proposed activities or strategies likely to improve PIR?

Features identified for evaluating the community planning process (nation-wide):
Based on the sections and requirements of the Community Planning Guidance, the following categories and features were identified. A ***Necessary*** (N) feature is one that was identified as essential to demonstrate compliance with the guidance. An ***Enhanced*** (E) feature was a feature that would support a rating of 'beyond the minimum.'

I. PLANNING GROUP COMPOSITION AND ORGANIZATION

A. OPENNESS

A1. Openness: Nominations

1. (N) Presence of bylaws or other written procedures for nomination to the planning group
2. (N) Documentation of the year's nomination process, which includes a description of the process used
3. (N) Evidence that a membership committee has been established
4. (N) Evidence that membership decisions involve more that just HD staff
5. (E) Evidence that nominations targeted membership gaps as identified by the Community Planning Group
6. (E) Multiple recruitment methods are used

A2. Openness: Selection

7. (N) A written documentation of selection process criteria established jointly by the HD and CPG
8. (N) Evidence that criteria (above) were used in selection of CPG members
9. (E) CPG-developed method of appeal described for declined membership
10. (E) Evidence that selection criteria is communicated to the public

B. PARTICIPATION AND INCLUSION

B1. Participation and Inclusion: Involvement of Broader Community

11. (N) Evidence that efforts were undertaken to accommodate or facilitate members who face challenging barriers (e.g. health care needs or economic needs) to their continued participation in the CPG
12. (N) Evidence of focus groups or ad hoc panels to gain input from *representatives of marginalized groups* who would be hard to recruit and/or retain as members of the planning group
13. (N) Evidence of focus groups or ad hoc panels to obtain input from *scientists or agency representatives* who would be hard to recruit and/or retain
14. (N) Evidence of by-laws or other governing rules including: clear decision-making rule (e.g., consensus, majority vote, etc.) and conflict management process
15. (N) Evidence of orientation, mentoring or training process for new CPG members.
16. (E) Evidence that CPG meetings are open to the public

17. (E) Evidence that the CPG has developed a mechanism that allows for the expression of varying opinions
18. (E) Evidence that a CPG utilizes a professional facilitator to ensure participation and inclusion of the broader community and enhance the planning process.

C. REPRESENTATION

C1. Representation: Affected Populations and Community Characteristics

19. (N) The CPG includes members who represent each population of the current and projected epidemic as documented in the epidemiologic profile.
20. Omit
21. (N) The CPG includes member(s) who have HIV infection
22. (N) Evidence that supports including the representation of each affected community (e.g. current or past risk, provider, advocate, members self-identify as part of the affected population)

The CPG includes members who represent the affect community in terms of:

23. (N) race/ethnicity
24. (N) gender
25. (N) sexual orientation
26. (N) geographic distribution
27. (E) age
28. (E) MSA size distribution (urban/rural)
29. (E) socioeconomic status

C2. Representation: Professional Expertise

Expertise is *readily available* from each of the following fields either through membership or some other appropriate consultation:

30. (N) evaluation
31. (N) epidemiology
32. (N) behavioral/social science
33. (N) service provision
34. (N) health planning
35. (N) Health Department: HIV/AIDS
36. (N) STD program representatives from state and local health departments
37. (E) state and local education agencies

Presence of representatives from governmental and non-governmental agencies providing the follow expertise:

38. (N) substance abuse
39. (N) HIV care and social services
40. (N) corrections
41. (E) mental health
42. (E) homeless services
43. (E) tuberculosis
44. (E) faith community
45. (E) business and labor

ATTACHMENT 3: CALENDAR OF MEETINGS AND MINUTES

Insert your documents/text here by cutting and pasting over these RED instructions. Please include a calendar of the planning group meetings and the minutes for any meeting where binding decisions were made. This may include only the full planning group meetings, or may require inclusion of relevant sub-group or sub-committee minutes.

ATTACHMENT 4: DECISION MAKING MODEL (WORKSHEETS) -OR- ALTERNATIVE DECISION MAKING MODEL (DETAIL)

Insert your documents/text here by cutting and pasting over these RED instructions. Include a copy of the SPG Decision-Making Model Guidance Worksheets if you used them for your process of prioritizing risk transmission categories and sub-categories. If you made any changes to the guidance process, please detail those changes and explain here. If you did not use the SPG Decision-Making Model Guidance but used another model, please detail the model here and include a copy here.

ATTACHMENT 5: EPIDEMIOLOGIC PROFILE

Insert your documents/text here by cutting and pasting over these RED instructions. Insert or attach a copy of your EPI Profile document here.

Features identified for evaluating the community planning process (nation-wide):

A. EPIDEMIOLOGIC PROFILE

A1. Epidemiologic Profile: 4 Key Questions

Extent to which the Epi Profile Guidance is organized to address the four key questions:

46. (N) What is the impact of HIV/AIDS on the population
47. (N) Who is at risk for becoming infected with HIV
48. (N) What is the geographic distribution of HIV/AIDS
49. (N) What are the sociodemographic characteristic of the population
50. (E) Inclusion of other pertinent jurisdictional characteristics as determined by the jurisdiction, e.g. who, when, where, and why are people testing for HIV; prevention medical status of HIV+ individuals; how soon do HIV-infected persons enter care after diagnosis; incarcerated individuals; substance abusers

A2. Epidemiologic Profile: Characteristics of Jurisdiction

The extent to which the EP considers each of the following sociodemographic characteristics of the *jurisdiction* in describing populations at risk for HIV infection in the EP

51. (N) race/ethnicity
52. (E) employment
53. (E) socioeconomic status/poverty
54. (E) homelessness
55. (E) significant cultural factors
56. (E) Inclusion of other pertinent jurisdictional characteristics as determine by the jurisdiction (e.g. population density (rural/urban), drug use, estimates of population sizes and corrections demographics
57. (E) Age as a characteristic of the jurisdiction
58. (E) Gender as a characteristic of the jurisdiction
59. (E) Geographic distribution of the population of the jurisdiction

A3. Epidemiologic Profile: Characteristics of Risk Populations

The extent to which at-risk populations are described in the EP in terms of each of the following socioeconomic characteristics:

60. (N) behavioral risk for transmission of HIV
61. (N) race/ethnicity
62. (N) age
63. (N) gender
64. (N) geographic distribution
65 (E) homelessness
66 (E) socioeconomic status/poverty
67 (E) primary language
68 (E) significant cultural and situational factors
69 (E) inclusion of other pertinent characteristics of risk populations as determined by the jurisdiction (e.g. drug usage, incarceration)
70 (E) size of population

A4. Epidemiologic Profile: Use of "Widely Available Data"

The extent to which the EP uses the following data sources characterized by CDC as 'widely available' and that are, in fact, available to that jurisdiction

71. (N) census
72. (N) vital statistics, e.g. teen pregnancy, prenatal care

73. (N) AIDS surveillance
74. (N) surveillance of bacterial sexually transmitted diseases
75. (N) seroincidence data
76. (N) seroprevalence data from STD clinic
77. (E) HIV screening of civilian application for military service
78. (E) HIV screening of Job Corp applicants
79. (E) youth risk behavior survey
80. (E) national HIV survey of childbearing women
81. (E) supplement to HIV/AIDS surveillance (SHAS)
82. (E) HIV/AIDS testing survey (HITS)
83. (E) seroprevalence data from drug treatment centers

A5. Epidemiologic Profile: Use of "Locally Available Data"
The extent to which the EP uses the following data sources characterized by CDC as "locally available" and that are, in fact, available in that jurisdiction
84. (N) HIV counseling and tesing data
85. (E) behavioral risk factor surveillance study (BRFSS)
86. (E) local behavioral studies

A6. Epidemiologic Profile: Content/Products of EP
87. (N) EP provides information about defined population at high risk for HIV infection for use by the CPG to prioritize
88. (N) EP contains a *narrative* explanation of *all available* data presented in a manner/language that enhances understanding of the CPG members
89. (N) Strengths and limitations of data sources used in the EP are described (general issues and jurisdiction-specific issues)
90. omit
91. omit
92. (N) Data gaps are explicitly identified in the EP
93. (N) EP provides a descriptive summary of the target populations for the CPG to consider
94. (N) EP is presented to CPG members in lay/understandable terminology
95. (N) Epi concepts and terms are defined
96. (E) EP provides a descriptive list of behaviorally-defined target populations with relevant demographic and jurisdictional characteristics used to define sub-populations within each
97. (E) Evidence of trend analysis or epi projections

ATTACHMENT 6: COMMUNITY RESOURCE INVENTORY

Insert your documents/text here by cutting and pasting over these RED instructions. Insert or attach a copy of your CRI here.

Features identified for evaluating the community planning process (nation-wide):

C. RESOURCE INVENTORY

Resource Inventory contains the following information about each provider:

111. (N) target populations served
112. (N) interventions provided to each population
113. (N) geographic coverage of interventions or programs offered
114. (E) number of people serviced over a specific time period by a particular intervention or program (i.e. service utilization)
115. (E) number of people who could be served by a particular intervention or program in a specific time period (i.e. service capacity)
116. (E) capabilities, philosophy, functions or goals of the organization
117. (E) information about potential linkages among organizations involved in similar or complementary activities
118. (E) information about the potential for coordinating community activities
119. (E) specific risk behavior is addressed
120. (E) sources of funding or other fiscal resources are identified
121. (E) criteria for inclusion in the RI
122. (E) evidence that there is consistent use of inclusion criteria
123. (E) evidence that the RI gathers and organizes information using the same population categories that the CPG will consider for prioritization
124. (E) upon completion of the RI, the CPG is provided with a summary of the findings.

ATTACHMENT 7: INTERVENTION PLANS FOR CDC FUNDED ACTIVITIES

Insert your documents/text here by cutting and pasting over these RED instructions. Attach or insert a copy of your Intervention Plans here.

ATTACHMENT 8: GAP ANALYSIS WORKSHEETS - OR - ALTERNATIVE GAP ANALYSIS MODEL (DETAIL)

Insert your documents/text here by cutting and pasting over these RED instructions. If your RPG developed a gap analysis and plan, in accordance with the SPG guidance, include copies of worksheets here. If your RPG utilized a method other than the SPG Guidance to develop the Gap Analysis, please provide the details of this method here.

ATTACHMENT 9: COST EFFECTIVENESS WORKSHEET - OR - ALTERNATIVE COST EFFECTIVENESS MODEL (DETAIL)

Insert your documents/text here by cutting and pasting over these RED instructions. If your RPG completed cost effectiveness analysis of the prevention interventions, as outlined in the SPG Cost Effectiveness Guidance, include copies of the worksheets here. If the RPG utilized a different method for the cost effectiveness analysis in making these determinations, detail the method here.

ATTACHMENT 10: ASSESSMENT REPORTS

Insert your documents/text here by cutting and pasting over these RED instructions. If the RPG completed any Target Population Assessments provide the assessment reports here.

ATTACHMENT 11: COMMUNITY PLANNING EVALUATION PLAN

Insert your documents/text here by cutting and pasting over these RED instructions. If the RPG developed a Community Planning Evaluation Plan include it here.

ATTACHMENT 12: OUTCOME EVALUATION PLAN

Insert your documents/text here by cutting and pasting over these RED instructions. If the RPG developed an Outcome Evaluation Plan include it here.

ATTACHMENT 13: LETTER OF CONCURRENCE/NON-CONCURRENCE

Insert your documents/text here by cutting and pasting over these RED instructions. Include a copy of your RPG Letter here.

FORM FOR REVIEW OF REGIONAL PLANS – REGION Z CROSS INDEX
10/26/00 Revision

This process is designed to provide a format for consistent review of the Regional HIV Prevention Plans. The purpose of the process is to determine the quality and outcome for planning based on SPG guidance and application of the guidance within each region. The review document is based on the SPG Plan Format. Please read the plan and thoroughly document your findings. A final summary report will be generated from your findings and the others in your group. All review forms will be submitted to DOH with the final report.

Yes and no answers are not helpful. Please clarify your findings with complete comments such as, "plan clearly addresses_____ because of the inclusion of_____ on page ____," or "plan only partially addresses the issue of _____ . The discussion lacks the element(s) _____, _____ and _____."

REGION REVIEWED _____ **REVIEWER** _____

A. DOES THE PLANNING PROCESS:

1. Foster openness and participation?

   a. Does the PIR plan discuss methods used for recruitment, retention and utilization of planning group members? How?
   Comments: **Page # 14**

   b. Does the PIR Plan identify the PIR needs of the planning group? What are they?
   Comments: **Page # 14**

   c. Are the proposed activities or strategies likely to improve PIR?
   Comments: **Page # 14**

d. Does the planning process reflect solicitation of community input at meeting on in some other manner?
Comments: **Page # 4**

e. Are meetings accessible and is accommodation provided?
Comments: **Page # 4**

2. Reflect the diversity of the epidemic and include appropriate experts?

a. Do the demographics reported in the planning group membership summary reflect:
1.) geographic distribution (i.e. counties, cities, towns, etc)

2.) the Epidemiologic Profile

3.) Other indicated demographic or surrogate markers (what?)

Comments: **Page # 4**

b. Does the planning group membership include experts in appropriate disciplines, including epidemiology, behavioral science, health planning and evaluation?
Comments: **Page # 4**

c. Does the planning group membership reflect the age, gender, race/ethnicity, socioeconomic status and identified at-risk populations indicated in the epidemiologic profile and other demographic indicators?
Comments: **Page # 4**

3. Ensure that prioritization of prevention needs are based on epidemiologic profile and needs assessments? (Decision Making Model)

   a. Are the results of the prioritization process consistent with the relevant data? With the method used?
   Comments: **Page # 6**

   b. Were any needs assessment(s) completed? If so, were they reflected in the prioritization process? (Gap Analysis)
   Comments: **Page # 6**

4. Ensure that interventions are prioritized based on effectiveness, theory and community norms and values?

   a. Did the prioritization of interventions include behavioral science and outcome effectiveness information?
   Comments: **Page # 8**

   b. Was cost analysis included in the consideration? If yes, how?
   Comments: **Page # 9**

   c. Were gaps in interventions or services identified and prioritized?
   Comments: **Page # 8**

   d. Was there a plan or discussion of how these gaps might to addressed or reduced?
   Comments: **Page # 8**

5. Foster strong logical links between community planning process and allocation of 100% of the CDC funds and 50% of the Omnibus funds?

a. Using the summary tables, do the allocations of resources reflect the plan priorities for populations and interventions?
Comments: **Page # 9**

b. Are 100% of the CDC and 50% of the Omnibus resource allocations targeting the priorities established in the regional plan?
Comments: **Page # 9**

c. If you reviewed the individual intervention plans, do you have any comments?
Comments:

B. DOES THE PROGRESS REPORT:

1. Indicate the successful prevention efforts in the region and areas of concern?
Comments: **Page# 11**

2. Were these concerns addressed in the Prevention Plan?
Comments: **Page # 11**

C. DOES THE PLAN ADDRESS LINKAGES WITH:

1. STD (STI) Services? **Page # 9**

2. TB Services? **Page # 9**

3. Mental Health? **Page # 9**

4. Substance Abuse? **Page # 9**

5. Ryan White? **Page # 10**

6. Other CDC or non-governmental HIV/AIDS efforts in the region? **Page # 10**

D. DOES THE EVALUATION PLAN CONTAIN:

1. A community planning evaluation plan? Has it been addressed this year? How will the findings effect next year?
   Comments: **Page # 11**

2. Were there any other evaluations of either the planning process or services indicated in the plan? If so, what?
   Comments: **Page # 11**

E. TECHNICAL ASSISTANCE:

Does the plan include requests for or reports on technical assistance needed or received?
Comments: **Page # 11**

F. IS THERE A LETTER OF CONCURRENCE? ISSUES? OR IS THERE A LETTER OF NON-CONCURRENCE? ISSUES? **Page # 12**

G. OTHER COMMENTS/CONCERNS:

Please indicate any other comments or concerns you might have about this plan and planning process. If there is something outstanding, please indicate. **Page #s ___**

DRAFT
FEATURES IDENTIFIED FOR EVALUATING THE COMMUNITY PLANNING PROCESS (NATION-WIDE) – REGION Z CROSS INDEX

Over the past 2 years, the Community Planning Evaluation Workgroup has identified the 'features' that would demonstrate that the CP Guidance (Supplemental) have been met. Through a process of abstracting and extracting information from the CDC submitted HIV Prevention Plan and the CDC Cooperative Agreement Application, these features will be reviewed. If these documents do not sufficiently support the presence of activities to support the features, then the CDC Project Officer, the jurisdiction (in this case – DOH) and the planning group will be asked to provide additional information. In Washington, this would include the Regional Planning Groups and AIDSNETs.

Washington State was selected as one of the pilot jurisdictions and the Plan/Application review has been completed. We will be hearing from CDC in the near future to continue the process. This may require that I talk with you or your planning group to develop a response for requested information. In addition, these features will eventually become part of the external review (CDC) process in the evaluation of the CDC application.

It seemed to me that these features could be used to clarify and enhance the HIV Prevention Plan writing process.

Based on the sections and requirements of the Community Planning Guidance, the following categories and features were identified. A ***Necessary*** (N) feature is one that was identified as essential to demonstrate compliance with the guidance. An ***Enhanced*** (E) feature was a feature that would support a rating of 'beyond the minimum.'

I. PLANNING GROUP COMPOSITION AND ORGANIZATION Page # 14

A. OPENNESS

A1. Openness: Nominations

1. (N) Presence of bylaws or other written procedures for nomination to the planning group
2. (N) Documentation of the year's nomination process, which includes a description of the process used
3. (N) Evidence that a membership committee has been established
4. (N) Evidence that membership decisions involve more that just HD staff
5. (E) Evidence that nominations targeted membership gaps as identified by the Community Planning Group
6. (E) Multiple recruitment methods are used

A2. Openness: Selection

7. (N) A written documentation of selection process criteria established jointly by the HD and CPG
8. (N) Evidence that criteria (above) were used in selection of CPG members
9. (E) CPG-developed method of appeal described for declined membership

10. (E) Evidence that selection criteria is communicated to the public

B. PARTICIPATION AND INCLUSION

B1. Participation and Inclusion: Involvement of Broader Community

11. (N) Evidence that efforts were undertaken to accommodate or facilitate members who face challenging barriers (e.g. health care needs or economic needs) to their continued participation in the CPG
12. (N) Evidence of focus groups or ad hoc panels to gain input from *representatives of marginalized groups* who would be hard to recruit and/or retain as members of the planning group
13. (N) Evidence of focus groups or ad hoc panels to obtain input from *scientists or agency representatives* who would be hard to recruit and/or retain
14. (N) Evidence of by-laws or other governing rules including: clear decision-making rule (e.g., consensus, majority vote, etc.) and conflict management process
15. (N) Evidence of orientation, mentoring or training process for new CPG members.
16. (E) Evidence that CPG meetings are open to the public
17. (E) Evidence that the CPG has developed a mechanism that allows for the expression of varying opinions
18. (E) Evidence that a CPG utilizes a professional facilitator to ensure participation and inclusion of the broader community and enhance the planning process.

C. REPRESENTATION

C1. Representation: Affected Populations and Community Characteristics

19. (N) The CPG includes members who represent each population of the current and projected epidemic as documented in the epidemiologic profile.
20. Omit
21. (N) The CPG includes member(s) who have HIV infection
22. (N) Evidence that supports including the representation of each affected community (e.g. current or past risk, provider, advocate, members self-identify as part of the affected population)

The CPG includes members who represent the affect community in terms of:

23. (N) race/ethnicity
24. (N) gender
25. (N) sexual orientation
26. (N) geographic distribution
27. (E) age
28. (E) MSA size distribution (urban/rural)
29. (E) socioeconomic status

C2. Representation: Professional Expertise

Expertise is *readily available* from each of the following fields either through membership or some other appropriate consultation:

30. (N) evaluation
31. (N) epidemiology
32. (N) behavioral/social science
33. (N) service provision
34. (N) health planning
35. (N) Health Department: HIV/AIDS
36. (N) STD program representatives from state and local health departments
37. (E) state and local education agencies

Presence of representatives from governmental and non-governmental agencies providing the follow expertise:

38. (N) substance abuse
39. (N) HIV care and social services
40. (N) corrections
41. (E) mental health
42. (E) homeless services
43. (E) tuberculosis
44. (E) faith community
45. (E) business and labor

II. PLANNING PROCESS

A. EPIDEMIOLOGIC PROFILE

Page # 18

A1. Epidemiologic Profile: 4 Key Questions

Extent to which the Epi Profile Guidance is organized to address the four key questions:

46. (N) What is the impact of HIV/AIDS on the population
47. (N) Who is at risk for becoming infected with HIV
48. (N) What is the geographic distribution of HIV/AIDS
49. (N) What are the sociodemographic characteristic of the population
50. (E) Inclusion of other pertinent jurisdictional characteristics as determined by the jurisdiction, e.g. who, when, where, and why are people testing for HIV; prevention medical status of HIV+ individuals; how soon do HIV-infected persons enter care after diagnosis; incarcerated individuals; substance abusers

A2. Epidemiologic Profile: Characteristics of Jurisdiction

The extent to which the EP considers each of the following sociodemographic characteristics of the *jurisdiction* in describing populations at risk for HIV infection in the EP

51. (N) race/ethnicity
52. (E) employment
53. (E) socioeconomic status/poverty
54. (E) homelessness
55. (E) significant cultural factors

56. (E) Inclusion of other pertinent jurisdictional characteristics as determine by the jurisdiction (e.g. population density (rural/urban), drug use, estimates of population sizes and corrections demographics
57. (E) Age as a characteristic of the jurisdiction
58. (E) Gender as a characteristic of the jurisdiction
59. (E) Geographic distribution of the population of the jurisdiction

A3. Epidemiologic Profile: Characteristics of Risk Populations

The extent to which at-risk populations are described in the EP in terms of each of the following socioeconomic characteristics:

60. (N) behavioral risk for transmission of HIV
61. (N) race/ethnicity
62. (N) age
63. (N) gender
64. (N) geographic distribution
65 (E) homelessness
66 (E) socioeconomic status/poverty
67 (E) primary language
68 (E) significant cultural and situational factors
69 (E) inclusion of other pertinent characteristics of risk populations as determined by the jurisdiction (e.g. drug usage, incarceration)
70 (E) size of population

A4. Epidemiologic Profile: Use of "Widely Available Data"

The extent to which the EP uses the following data sources characterized by CDC as 'widely available' and that are, in fact, available to that jurisdiction

71. (N) census
72. (N) vital statistics, e.g. teen pregnancy, prenatal care
73. (N) AIDS surveillance
74. (N) surveillance of bacterial sexually transmitted diseases
75. (N) seroincidence data
76. (N) seroprevalence data from STD clinic
77. (E) HIV screening of civilian application for military service
78. (E) HIV screening of Job Corp applicants
79. (E) youth risk behavior survey
80. (E) national HIV survey of childbearing women
81. (E) supplement to HIV/AIDS surveillance (SHAS)
82. (E) HIV/AIDS testing survey (HITS)
83. (E) seroprevalence data from drug treatment centers

A5. Epidemiologic Profile: Use of "Locally Available Data"

The extent to which the EP uses the following data sources characterized by CDC as "locally available" and that are, in fact, available in that jurisdiction

84. (N) HIV counseling and tesing data
85. (E) behavioral risk factor surveillance study (BRFSS)
86. (E) local behavioral studies

A6. Epidemiologic Profile: Content/Products of EP

87. (N) EP provides information about defined population at high risk for HIV infection for use by the CPG to prioritize
88. (N) EP contains a *narrative* explanation of *all available* data presented in a manner/language that enhances understanding of the CPG members
89. (N) Strengths and limitations of data sources used in the EP are described (general issues and jurisdiction-specific issues)
90. omit
91. omit
92. (N) Data gaps are explicitly identified in the EP
93. (N) EP provides a descriptive summary of the target populations for the CPG to consider
94. (N) EP is presented to CPG members in lay/understandable terminology
95. (N) Epi concepts and terms are defined
96. (E) EP provides a descriptive list of behaviorally-defined target populations with relevant demographic and jurisdictional characteristics used to define sub-populations within each
97. (E) Evidence of trend analysis or epi projections

B. NEEDS ASSESSMENT **Page # 10**

98. (N) Needs assessments focus on population identified in the EP
99. (N) Extent to which decisions about the data that are needed are determined jointly by CPG members and health department staff
100. (N) Evidence of explicit roles and responsibilities of HD staff, CPG members and external consultants in conducting Needs Assessments is documented
101. (N) Extent to which distribution of funds for needs assessments is determined with input from CPG members and health department staff.
102. (E) Data are gathered that define populations' needs in terms of knowledge, skills, attitudes, norms and access to services (KABB)
103. (E) Multiple data collection methods were used to conduct needs assessments, e.g. qualitative and quantitative

Prior to the execution of the NA, the CPG was provided with the following information about the NA:

104. (N) Purpose and objectives (desired outcomes, scope)
105. (N) Research questions
106. (N) Populations of specific focus
107. (N) Data collection and analysis methods
108. (N) Time line/Work Plan
109. (N) NA are current and meet the decision-making needs of the CPG
110 (E) Upon completion of the NA, the CPG was provided with a summary of the findings

C. RESOURCE INVENTORY **Page # 20**

Resource Inventory contains the following information about each provider:

111. (N) target populations served
112. (N) interventions provided to each population

113. (N) geographic coverage of interventions or programs offered
114. (E) number of people serviced over a specific time period by a particular intervention or program (i.e. service utilization)
115. (E) number of people who could be served by a particular intervention or program in a specific time period (i.e. service capacity)
116. (E) capabilities, philosophy, functions or goals of the organization
117. (E) information about potential linkages among organizations involved in similar or complementary activities
118. (E) information about the potential for coordinating community activities
119. (E) specific risk behavior is addressed
120. (E) sources of funding or other fiscal resources are identified
121. (E) criteria for inclusion in the RI
122. (E) evidence that there is consistent use of inclusion criteria
123. (E) evidence that the RI gathers and organizes information using the same population categories that the CPG will consider for prioritization
124. (E) upon completion of the RI, the CPG is provided with a summary of the findings.

D. GAP ANALYSIS **Page # 8**

125. (N) The GA addresses each of the risk populations identified in the EP
    i. GA includes data from the following sources:
126. (N) Epidemiologic Profile
127. (N) Needs Assessment
128. (N) Resource Inventory
129. (N) The GA specifically identifies both met and unmet needs
130. (N) The GA identifies the portion of *met* needs
131. (N) The GA addresses availability or accessibility of (or barriers to) existing services
132. (E) The GA provides an estimate of needs for each target population including both programmatic and fiscal needs
133. (E) Upon completion of the GA, the CPG was provided with a summary of the findings

III. DEVELOPING A COMPREHENSIVE PLAN

A. PRIORITY SETTING **Page # 5**

A1. Priority Setting: Target Populations
Evidence that all of the following factors were considered in a systematic fashion when prioritizing risk populations

Some *systematic approaches* include (not an exhaustive list)

- a weighed variable approach
- a cost benefit analysis
- an epi-mapping approach
- consensus
- modified consensus

- consensus/voting
- voting
- formula

134. (N) size of at-risk population
135. (N) HIV seroprevalence, if available
136. (N) Prevalence of risky behavior in the population
137. (N) Extent of **CDC** resources currently targeting the population
138. (E) Extent of **non-CDC** resources currently targeting the population
139. (E) Multiple high risk populations within the target population defined by demographics and/or behavioral factors (e.g. African American pregnant women who may be HIV infected; young IDU; young MSM who are having UAI)
140. (E) Difficulty of meeting need
141. (E) Emerging issues (trends in the epi or issues for which limited data are available)
142. (N) Clear statement describing why each high priority population was chosen (may include finding in epi profile)

A2. Priority Setting: Interventions **Page # 5**

Evidence that all of the following factors were considered in a systematic fashion when prioritizing interventions

143. (N) Demonstrated application of existing behavioral and social science evidence (including evaluation data when available) to show effectiveness in averting or reducing high-risk behavior within the target population
144. (N) Evidence that intervention is acceptable to target population (in keeping with norms and values)
145. (N) Evidence that the intervention is feasible to implement for its intended population and in its intended setting
146. (N) Evidence that intervention was developed by or with input from the target population (may be part of the literature)
147. (E) Evidence that the availability of other governmental and non-governmental resources (including private sector) for HIV prevention interventions was considered in a systematic way
148. (E) Evidence that the intervention is cost effective
149. (E) Evidence that the intervention is sustainable over time
150. omit
151. (E) Clear statement describing why each intervention was chosen

A3. Priority Setting: Scientific Evidence for Interventions **Page # 6**

Evidence of the application of knowledge from existing behavioral and social science/evidence to show effectiveness in averting or reducing high-risk behavior within the target population. The proposed intervention has:

152. (N) undergone previous evaluation in current setting
153. (N) been implemented in *similar* context (setting and population) and evaluated by others

154. (N) been implemented in *different* context (setting or population) and evaluated by others
155. (N) applied formal theory in program development
156. (N) applied informal theory in program development
157. (N) used another type of scientific evidence

B. The Comprehensive Plan **Page # 5**

Populations

158. (N) Populations are prioritized/ranked by risk
159. (N) Populations are ***behaviorally*** risk based (vs. identity based) (the reason the population is identified is based on actual known behaviors or potential for behaviors that put them at risk for transmission. May be subdivided by other demographic characteristics, e.g. MSM under the age of 24 who participate in UAI; African American women who are sex partners of heterosexually identified MSM or needle sharing men. General population is NOT a risk-based population
160. (N) other characteristics routinely described (e.g. geographic or demographic characteristics)

Interventions **Page # 6**

161. (N) prioritized/rank by risk population
162. (N) inclusion of *general* description of proposed interventions
163. (N) inclusion of *general* description of existing intervention
164. (E) inclusion of *specific* definitions, characteristics or criteria for each type of proposed and existing intervention (i.e. the CP says MORE than 'do individual levl interventions for MSM')
165. (E) inclusion of *specific* descriptions of proposed interventions
166. (E) inclusion of *specific* description of existing interventions
167. (E) inclusion of intervention strategies beyond those which health department funds might support (i.e. needle exchange is not funded through federal dollars, but funding is secured from other sources)
168. (E) Inclusion of specific cultural, social or political factos that could impact the strategies suggested by communities
169. (N) Explicit demonstration of linkages between the comprehensive plan and the application for CDC funding (e.g. budget information on Intervention Plans)
170. (N) Explicit demonstration of linkages between the comprehensive plan and funded interventions
171. (E) Evidence of the linkages between the needs assessment, resource inventory and gap analysis in the development of the comprehensive plan

IV. LETTER OF CONCURRENCE **Pages # 11 and 27**

Evidence that a letter of concurrence has been determined and that the CPG members have participated in its formulation.

In May 2002, the Pilot Projects will meet and review the process, with determination of appropriate modifications to this process and these features.

ATTACHMENT 2

APRIL 2002 PRESENTATION OF RECOMMENDED EFFECTIVE INTERVENTIONS

Effective and Promising Men who have Sex with Men HIV Prevention Matrix 2002

MSM HIV Positive (not prioritized)

Demographics:	Setting:	Program example:	Intervention type:	Science/Theory:
18 years old and older	CBO (Seattle, Spokane)	Positive Power HIV/AIDS Project Development and Evaluation Unit (HAPEU) University of Washington	Group-level	1. Theory of Reason Action 2. Relapse Prevention Model

Core Elements:

- Co-facilitated by a trained facilitators who have skills working with groups.
- Comprised of 6 consecutive 120 minute sessions
- The first session is a group commitment to ones self and the group as a whole to their issues.
- Each session contains breathing and check-in exercise to facilitate the group dynamic and the ability to be present.
- Participants establish personal goals and provide self-motivating statements. Individuals provide self-prescribed actions aimed at a specific behavior change.
- Sessions Include skills building exercise developing communication, and disclosure of HIV status.
- Individuals work on accessing core issues and state how these impact their ability to disclose HIV status or make changes in their lives. Discussions are used to help start solutions for situations in participants lives.
- Participants create a personal mission statement that enables them to examine their behavior in comparison with their core values.

Findings:

Through outcome evaluation using a pre and post survey design with a 5-week interval. initial findings show

1. A significant decrease in depression.
2. A significant decrease in frequency to "If he says "no condoms", I'll have sex anyway" (Attitude 7, from 3.8 to 4.1; 1 is always 5 is never)
3. Significant increase in sexual activity, but the sexual activity is lower risk sexual activities. Higher risk activities went from an average of .72 to .71 (which is no change) while lower risk activities (everything but unprotected anal intercourse with HIV negative individuals) went from 3.4 to 5.4.
4. Significant increases in comfort of disclosing HIV status. This means that all together, the individuals report a significant bit more comfort in disclosing status from 1.9 to 1.8 in this case, 1 means comfort.

HIV Positive (not prioritized)

Demographics:	Setting:	Program example:	Intervention type:	Science/Theory:
21-45 years old	University (Seattle)	Project SHAPE University of Washington School of Social Work	Individual	1. Theory of Reason Action 2. Stages of Change 3. Motivational Interviewing

Core Elements:

- Personal assessments of behaviors, values, attitudes and beliefs.
- In a feedback session, use Motivational Interviewing strategies to facilitate a discussion of discrepancies between and ambivalence about risky sexual behaviors & attitudes, values, and beliefs.

Findings:

Six-month follow-up data show a 31% reduction in the proportions of participants reporting unprotected anal sex with a partner of negative or unknown serostatus.

MSM HIV Positive (not prioritized)

Demographics:	**Setting:**	**Program example:**	**Intervention type:**	**Science/Theory:**
Newly diagnosed, multiple partners, use of party drugs, and frequent public sex environments	CBO, and Clinic (Spokane, North Idaho, Seattle)	Prevention Case Management (PCM) Center for Disease Control Prevention Case Management Guidance (1997) Milestone, and Positive Voice Spokane AIDS Network, Lifelong AIDS Alliance, Haborview, Madison clinic, One-On -One	Individual	1. Stages of Change 2. Motivational Interviewing 3. Hybrid of risk reduction counseling and traditional case management

Core Elements:

- Protocols for client engagement and related follow-ups must be developed, such as requiring a minimum of follow-up contacts within a specified time period.
- PCM programs staff must develop screening procedures to identify persons at highest risk for acquiring or transmitting HIV
- Thorough and comprehensive assessment instruments(s) must be obtained or developed to assess HIV, STD, and substance abuse risks along with related medical and psychosocial needs.
- Standards for development of a client-centered prevention plan
- Multiple-session HIV risk-reduction counseling aimed at meeting identified behavioral objectives must be provided to all PCM clients
- Formal and informal agreements, such as memoranda of understandings, must be established with relevant service providers to ensure availability and access to key service referrals
- A referral tracking system must be maintained.
- A mechanism to provide clients with emergency psychological or medical services must be established.
- Standards for monitoring and reassessing clients' needs and progress
- Provide on-going individualize prevention counseling, support and service brokerage.
- Clients complete a sexual assessment and counseling session followed by a 3month and 6 month follow up.

Findings:

PCM is currently under outcome evaluation by Project SHAPE with the University of Washington and only initial information is available.

From baseline to follow-up, there was a 66% reduction of client self-reporting high-risk behavior (Lifelong AIDS Alliance).
There was no change in the risk behavior reported by clients, but few reported risk behavior at baseline so there was less room for change (Haborview/Madison Clinic)

HIV Positive (not prioritized)

Demographics:	**Setting:**	**Program example:**	**Intervention type:**	**Science/Theory:**
all ages	Collaboration of agencies (Los Angles)	Positive Images Collaborative effort	Individual-level Group-level	1. Health Belief Model 2. Social Learning Theory

Core Elements:

- Collaboration with multi-agencies
- Provide or create social networks to promote self-esteem and self-efficacy to practice safe sex, encourage clients to reduce risk of co-infection with STDs, promote testing.
- Telephone chat line
- 2 ½ hour sessions
- Facilitated by peer staff members
- Offer several MSM HIV positive sub-population specific groups and drop in support groups.

Findings:

Not noted in reference material

MSM HIV Positive (not prioritized)

Demographics:	**Setting:**	**Program example:**	**Intervention type:**	**Science/Theory:**
all ages also used with Negative MSM	Larger urban areas Boston, Seattle	AIDS Action Committee (AAC) Boston Gay Men's Health Project (Gay City) Seattle Public Health Seattle and King County HEP Squad (PHSKC) King County	Social Marketing	1. Social Marketing Theory 2. Multifaceted Community Mobilization 3. Social Learning Theory

Core Elements:

- Communities that have larger gay communities
- Large media campaign that promote call to actions.
- Develop culturally relevant message
- Focus groups used to determine message that involves MSM being served.
- Involvement of MSM in development and implementation of campaign
- Collaboration with a the prevention system and establishing a referral mechanism for inter agency referral.
- Posting posters in gay venues, i.e. bars, bathhouses, paper media, billboards, transit, and businesses
- Uses survey component to establish reach and effectiveness of message with target market

Findings:

Surveys of men leaving gay bar restrooms showed 70% unprompted recall of 2 or more messages.

MSM People of Color (Not prioritized)

Demographics:	Setting:	Program example:	Intervention type:	Science/Theory:
MSM Latino (Immigrant Spanish speaking MSM)	San Francisco Gay bars and venues	Hermanos de Luna Y Sol (HLS) Rafael M. Diaz and Jose Ramon Fernandez-Pena	Street-outreach Group-level	1. Social Learning Theory 2. Behavioral Intervention 3. Cognitive Intervention

Core Elements:

- Focus on modifying high-risk sexual behavior, which is a result of socioculturual factors that contribute to, decreased self-esteem, perception of low sexual control, sense of isolation, and fatalism about HIV infection.
- Includes bar outreach and recruitment of gay Latino bar patrons using short survey to stimulate discussion.
- After survey condoms, brochures, and non-alcoholic drink token were given out.
- 4 small group sessions each lasting 2 hours.
- Facilitated by 2 Latino gay men trained in health education.
- Sessions devoted to exploring lives as Latino gay men, impact of AIDS on lives and sexuality, practicing safer sex and training in how to use a safer sex journal.
- Follow-up activities to ensure that sustained behavior change.

Findings:

Preliminary pre post data showed

1. Increases in anal intercourse, but decreases in number of sexual partners
2. 80 percent of those reporting increases in anal intercourse reported consistent condom use.
3. For all men in follow-up sample, consistent condom use increased from 50 to 58 percent for IAI and from 33 to 58 percent for RAI.

MSM People of Color (Not prioritized)

Demographics:	Setting:	Program example:	Intervention type:	Science/Theory:
MSM Asian and Pacific Islander 18 years and older	San Francisco CBO	Hot, Healthy and Keeping it UP! (HHKIU) Case Studies in Effective AIDS Prevention , Sociometrics (Intervention in a box) Choi et al. (1996)	Group-level	1. Health Belief Model 2. Social Cognitive Theory 3. Theory of Reasoned Action

Core Elements:

- Co-facilitated by trained health educator and peer volunteer
- Sessions varied from initial one session to 6 one hour sessions
- Includes lecture, group discussion, brainstorming, skill demonstration and practice, team-based games, and role-play.
- The intervention fosters development of positive ethnic and sexual identity in order to help participants acknowledge and control behaviors that put them at risk for HIV.
- Intervention should address the following topics/issues: developing positive self-identity and social support, learning about HIV/AIDS and safer sex practices, re-conceptualizing condom use as both erotic and important, and developing safer-sex negotiation skills.

Findings:

At baseline and 3month follow-up:

1. Members of the intervention group reported significantly fewer partners than control group (3.9 vs. 6.4). Ethnicity had no bearing on participants' change in number of partners.
2. Although the effect of treatment on unprotected anal intercourse was not statistically significant for the intervention group as a whole, analysis revealed Chinese and Filipino men reduced UAI by more than 50%.
3. Intervention participants became more knowledgeable about AIDS. Participants also became more worried about contracting HIV.
4. Ethnicity had a statistically significant effect on intervention results. Participants from certain ethnic groups received additional benefits from intervention. Chinese and Filipino participants were significantly

MSM People of Color (Not prioritized)

Demographics: African American MSM 21 years and older	**Setting:** San Francisco CBO and STD clinics	**Program example:** Brother-To-Brother Case Studies in Effective AIDS Prevention , Sociometrics (Intervention in a box)	**Intervention type:** Group-level	**Science/Theory:** 1. AIDS Risk Reduction Model

Core Elements: • Peer facilitated • Includes role playing, group discussion, and behavioral skills exercise • The intervention has 3 three hour sessions occurring one week apart • Uses sexually explicit films and multimedia to presentation of sexual behaviors.	**Findings:**

MSM People of Color (Not prioritized)

Demographics: African American MSM with high substance abuse usage	**Setting:** Substance abuse treatment facilities and CBOs Detroit	**Program example:** JEMADARI 2001 National HIV Prevention Conference Michigan State University, Sirls, G_F: Grant, I.	**Intervention type:** Group-level Client-centered	**Science/Theory:** 1. Social Learning Theory

Core Elements: • Consists of five-week series of 10 HIV empowerment workshops designed to eliminate barriers to HIV risk reduction. • Promotes a sense of self, dignity, pride and community • Imparts skills that will empower men not only to effectively deal with intra and interpersonal relationships but also to better confront/negotiate the social context. • Produce group participants who will be a source of social support required initiating and sustaining risk reduction as well as agents for positive change. • On-site HIV counseling and testing is offered to program participants. • Men are invited to participate in a after care program which consist of a series of support groups and educational forums designed to consolidate and reinforce behavioral changes and gains made during the program.	**Findings:** Program had a profound impact on the lives of participants, which resulted in; 1. Workshop participants having demonstrated significant increases in knowledge about HIV and STDs 2. A more realistic shift in there perceived vulnerability to acquire HIV. 3. An increased condom use. 4. Improvement in both personal and professional relationships and a willingness to impart information to their companions.

MSM People of Color (Not prioritized)

Demographics: Non-gay-identified African-American MSM	**Setting:** Barber-shops	**Program example:** Brother-To-Brother Down Low Barbershop Project	**Intervention type:** Community-level intervention	**Science/Theory:** 1. Diffusion of Innovation model that uses key opinion leaders as HIV prevention educators. 2. Barber workshop curriculum based on Health Belief Model.

Core Elements: • Recruits and trains African-American barbers to be peer educators. • Barbers and BTB staff conduct risk reduction education sessions in barbershops.. Counseling and testing will be available at the sessions. • Passive distribution of risk reduction supplies in barbershops.	**Findings:** None. This is a new program.

MSM IDU (Not prioritized)

Demographics:	Setting:	Program example:	Intervention type:	Science/Theory:
Non-gay identified MSM and high risk youth	5 cities Seattle	Community PROMISE: Peers Reaching Out and Modeling Intervention Strategies for HIV/AIDS Risk Reduction in their Community Part of the CDC AIDS Community Demonstration Project Research Group (1999) and a CDC replicated program. Package program	Community-level Street-outreach	1. Transtheoretical model of behavior 2. Theory of Reasoned Action 3. Social Cognitive Theory

Core Elements:

- Promotes progress toward consistent HIV prevention through community mobilization and distribution of small-media materials and risk reduction supplies, such as condoms and bleach.
- Peers are recruited and trained to be community advocates and to distribute role model stories and risk reduction supplies on the streets of their communities
- Creating role model stories based on personal accounts from individuals in the target population who already have made some risk-reduction behavior change.
- Role model stories are reinforced by interpersonal communications with the community advocates.
- Each week, community advocates distribute stories and supplies to 10-20 of their peers.

Findings:

Significant movement by community members toward consistent condom use with their main and non-main partners.

MSM IDU (Not prioritized)

Demographics:	Setting:	Program example:	Intervention type:	Science/Theory:
MSM Crystal Meth Injectors	Seattle gay venues, private homes, and drug treatment center	Project NEON (Needle and sex Education Outreach Network)	Community-level	1. Stages of Change

Core Elements:

- Primary goal is to normalize safer sex and drug use behavior by promoting 1) consistent use of protection for anal sex, 2) single use of clean injection equipment, and 3) better management or discontinuation of crystal use.
- Tiered, mutually supporting program components designed for each level of behavior change to encourage engagement and movement along change continuum.
- Components include print- and web-based health education materials, peer education, needle exchange, distribution of risk reduction tools, and clinical services including individual and group-level counseling addressing both drug use and sexual risk reduction.

Findings:

Although funding does not provide for full outcome evaluation, the strength of the model is demonstrated by:

- 40% of counseling clients move into abstinence within 6 months of starting counseling.
- Significant decreases in drug use among peer education team.
- Increased press runs of all materials in response to growing popularity and demand.
- Peer education team averages 2,500 contacts each year; counseling services reach avg 120 men each year.

Local prevalence data suggests a leveling or decline in infection rates among target population over last five years.

<table>
<tr><td colspan="5">MSM IDU (Not prioritized)</td></tr>
<tr><td>Demographics:
MSM IDU
Methamphetamine users</td><td>Setting:
Drug treatment center
California</td><td>Program example:
The Friends Research Institute in California
JAMA web site 61st Annual Scientific Meeting of College on Problems of Drug Dependence.</td><td>Intervention type:
Group-level
Individual-level</td><td>Science/Theory:
1. Behavioral Interventions
2. Relapse Prevention</td></tr>
<tr><td colspan="3">Core Elements:
• 16 week behavioral treatment
• Treatments conditions include contingency a combination of contingency management and relapse prevention
• In contingency management subjects were paid increasing amounts of money as their number of successive negative urine samples increased.</td><td colspan="2">Findings:
Preliminary findings for 43 clients showed that treatment retention and effectiveness was higher for subjects in the two contingency management groups and lowest for those in the relapse prevention group. The addition of gay-specific HIV risk education was not associated with greater retention or treatment effectiveness. Regardless of treatment group, over the 16-week treatment period participants significantly reduced the number of sexual partners.</td></tr>
</table>

MSM General (Not prioritized)

Demographics:	**Setting:**	**Program example:**	**Intervention type:**	**Science/Theory:**
MSM 21years and older Men who frequent gay bars and venues	Gay bars in small cities (50-75,000) that were at least 60 miles away from larger cities. (geographicall y compact social environment	Popular Opinion Leader (POL) local example of Project is The Friend-To-Friend Project (FTFP). HIV/AIDS Projects Development and Evaluation Unit (HAPDEU), University of Washington. Program is a CDC replicated study, in the CDC Compendium of HIV Prevention Interventions with Evidence of Effectiveness (1999), and Effective AIDS Prevention Sociometrics Jeffrey A. Kelly	Community-level	1. Diffusion of Innovation Theory 2. Social Influence principles 3. Social Learning Theory (FTFP) 4. Stages of Change Model (FTFP) 5. Relapse Prevention (FTFP)

Core Elements:

This program is based on a program that identifies, trains, and enlists the help of key opinion leaders to change risky sexual norms and behaviors in the gay community. Well-liked men who frequent gay bars are trained to endorse safer sexual behaviors in casual, one-on-one conversations with peers at the bars and other settings. During these conversations, the "popular opinion leader" corrects misperceptions, discusses the importance of HIV prevention, describes strategies he uses to reduce his own risk (e.g., keeping condoms nearby, avoiding sex when intoxicated, resisting coercion for unsafe sex), and recommends that the peer adopt safer sex behaviors. Popular opinion leaders wear buttons, shirt or hats displaying project logo, which is also on posters around the bars, as a conversation –starting technique. Each leader agrees to have at least 14 such conversations and to recruit another popular opinion leader.

The intervention has two phases:

- Identifying and enlisting the support of popular and well-liked opinion leaders to take on risk-reduction advocacy roles, training cadres of opinion leaders to disseminate risk-reduction endorsement messages within their own social networks.
- Second phase is message dissemination, which consist of health promotion conversations in the bar and ongoing endorsement of norms in the community.
- The workshops are co-facilitated
- All opinion leaders attend four weekly 90-minute training sessions.
- Facilitators review critical information about HIV epidemiology, key high-risk behaviors, and risk-reduction strategies.
- Second session, participants learn how to be effective health promoters by focusing on: sensitizing others to the threat of AIDS, emphasizing the feasibility of behavioral change, suggesting practical strategies, and self-endorsing risk-reduction behaviors to help avoid a preachy tone.
- In the third session, the facilitators' model sample health promotion conversations then lead a group discussion about these conversations. Participants practice conversation strategies using role-play then identify four friends with whom they can initiate health promotion discussions in the next week.
- The fourth session the facilitators review the results of the past week's conversations and offer new strategies and problem solving techniques. All participants then sign a contract in which they agree to have at least 10 health promotion conversations in the next two weeks, and report on these conversations to the facilitators via monitoring forms.

Findings:

The evaluation of this community-wide intervention revealed that dissemination of risk-reduction messages and strategies through the recruitment and training of popular opinion leaders was and effective strategy for changing community behavior patterns and community perception of norms surrounding sexual behavior.The POL intervention produced the following results among patrons of bars where the program was conducted.

1. Unprotected anal intercourse decreased from 15 to 29 percent
2. Condom use increased
3. Number of sex partner decreased
4. There were increases in the perceived acceptability of safer sex from baseline to post-intervention surveys.
5. At a 3 year follow-up (St. Lawrence et al., 1994), reductions in UAI and increases in condom use continue to occur.

Some cities exhibited a lesser degree of success, which had lower baseline levels of key risk behaviors such as unprotected anal intercourse, this may suggest that this strategy is more effective in a high-risk population which may be (relatively) naïve to risk-reduction and health promotion campaigns.

The Friend-To-Friend Project is currently undergoing an extensive outcome evaluation findings have not yet been completed.

MSM General (Not prioritized)

Demographics:	**Setting:**	**Program example:**	**Intervention type:**	**Science/Theory:**
MSM 21years and older	Medium sized American city (400,000) University	Behavioral Intervention to Reduce AIDS Risk Activities among Gay Men (BIGM) University of Mississippi Medical Center and Jackson State University Prevention Interventions with Evidence of Effectiveness (1999), and Effective AIDS Prevention Sociometrics Jeffrey A. Kelly (1989)(1990)	Group-level	1. HIV/AIDS education strategies 2. Behavioral self-management 3. Assertiveness Training

Core Elements:

- 12-session group counseling intervention designed to reduce sex-related HIV/AIDS-risk behaviors among gay men.
- Helps workshop participants to identify and acknowledge his own behavior patterns before working to change those patterns.
- The twelve intervention sessions are divided into five consecutive phases: 1) AIDS education 2) behavioral self-management 3) assertiveness training 4) relationship skills/social support development 5) a final evaluative session in which participants identify the changes they have made.
- Sessions are 90 minutes long
- Each session is led by two clinical psychologists and two project assistants and includes psycho-educational activities such as role-play, personal goal-setting, and group problem solving.

Findings:

- In comparison to control groups subjects, members of the immediate intervention group significantly reduced the frequency with which they engaged in unprotected anal intercourse and increased the frequency with which they used condoms during intercourse.
- The immediate intervention group and control group demonstrated no significant difference in oral/anal contact, oral/genital practices, digital/anal activity, or number of sexual partners.
- Members of the immediate intervention group scored significantly higher than members of the control group on the AIDS risk knowledge test.
- Member of the immediate intervention group demonstrated significantly greater skill in handling casual propositions and coercion to engage in high-risk activities than did members of the control group
- BIGM was not successful in reducing the number of partners among intervention participants.

MSM General (Not prioritized)

Demographics:	Setting:	Program example:	Intervention type:	Science/Theory:
MSM	GLBTQ Community Center in San Diego	Integrated HIV Prevention for Gay Men: The Open Door Between Mental Health and Prevention Services Berberet, HM, Jacobs, DA San Diego State University The Lesbian and Gay Men's Community Center of San Diego Alliant University	Individual-level Street-outreach	1. Hybrid of case management

Core Elements:

The HIV Prevention Department (HPD) and Mental Health Services (MHS) work collaborative to provide multiple access points and interventions for MSM and HIV positive Individuals.

- Facilitate consumer access from access from either department, MHS and HPD cross-refer, utilize complementary outcome objectives, and collaborate on the development and refinement of services.
- Targeted high-risk MSM for intensive individual and group psychotherapy.
- HPD conducts street, bar, bathhouse, and public park outreach and make referrals.
- MSH assesses and treats appropriate individuals, addressing issues correlated with high-risk sexual behavior including chemical dependency, victimization, and depression.
- MSH has adopted a prevention focus and makes referral for adjunctive/discharge services to HPDs' multiple peer-based educational an social interventions. HIV positive MSM are also referred to all HPD prevention services to assist in developing a secondary prevention perspective for these individuals.

Findings:

Three primary benefits have resulted from this interdisciplinary approach;

1. The opportunity to provide intensive, psychologically based HIV prevention interventions to individuals not normally in mental treatment
2. The opportunity to access high-risk individuals identified through mental health treatment
3. The opportunity to provide cost-effective prevention services to the HIV positive community.

MSM General (Not prioritized)				
Demographics: MSM Internet Online sex seekers and users of chat rooms 18 years and older	**Setting:** Gay.com and AOL.com chat rooms San Francisco Seattle CBOs	**Program example:** Dot.com (Stop AIDS Project), San Francisco Prevention Organization With Empowerment Resources On the Net (PowerON!), HIV/AIDS Projects Development and Evaluation Unit, University of Washington, Seattle Lifelong AIDS Alliance, Seattle Public Health King County, Seattle	**Intervention type:** Street-outreach	**Science/Theory:** 1. Social Learning Theory 2. Diffusion of Innovation Theory (PoweON!) 3. Social Marketing Theory (PowerON!)

Core Elements:

- Staffed by core volunteers
- Topics discussed cover both HIV and STDs transmission and how what effect each has on the other.
- Volunteer use provocative member profiles to identify them as outreach workers
- Health educators can be contracted by chat room participants by using instant messages to receive safer sex and referral information
- Website (PowerON!) provides all Prevention and community information for MSM in one location. Website uses video/audio streaming to portray role model stories and safer sex negotiation encounters to chat room users. The website users will be able to take HIV/STD-risk self assessments quizzes and receive immediate feedback information on their own risk level.
- Volunteers conduct health promotion conversation in main chat room with other volunteer and room participants. Volunteers introduce safe sex topics in the main chat and conduct open discussion in main chat to help endorse safer sex norms in chat rooms (PowerON!)
- Volunteers referrer MSM chatter to PowerON! website to view role model stories and also send electronic format greeting of role model story to 10 of their online friends.
- Media campaign promotes Website offline in all gay venues.
- Project collaborates with all other prevention organizations to help co-facilitate and conduct bi-monthly online forum discussion current safer sex topics.
- Volunteers promote counseling and testing and referral chatters where they can be tested and screened for HIV/STD

Findings:

Findings on these interventions have not been conducted yet. However, references to the value of the internet has concerning HIV/STD and health information has been sited by other research articles done on the topic:

The Web Outreach Program at Stop AIDS has succeeded at identifying an involving gay an bisexual men in the implementation of HIV prevention programs at a time when many MSM no longer perceive HIV transmission to be a severe public health threat. The Web Outreach Program is an innovative and accessible program, which supports the mission of STOP AIDS to build HIV prevention through community-based organizing.

Results from the intervention have been instrumental in meeting and assessing individual risk and the HIV prevention needs of gay and bisexual men who are meeting for sex. " We have answered hundred of questions ranging from the risk of contracting HIV from oral sex to STD transmission". This invention has provided a valuable entrée to talking about issues such as "barebacking", disclosure and other issues, which resonate with men in the online community.

- Among all 15- to 24-year-olds, nine out of ten (90 percent) have gone online. More than two out of three (68 percent) have gotten health information online.
- Among the online health seekers, four out of ten (39 percent, or 27 percent of all respondents) look up health information at least once a month.
- Four out of ten (39 percent) say they generally find online health information "very useful" while just 5 percent say it's generally "not too" and 1 percent "not at all" useful.
- Four out of ten (39 percent, or 26 percent of all respondents) say they have changed their personal behavior because of health information they got online.
- One in seven (14 percent) have seen a doctor or other health provider because of health information they got online
- More young people (84 percent) consider sexual health issues AIDS and other STDs to be "very important" for people their age compared to any other health issue asked about in the survey.
- Among online youth, those most likely to look for information on HIV/AIDS include African-Americans (45 percent vs. 26 percent of whites), (33 percent of 15- to 19-year-olds vs. 26 percent of 20- to 24- year-olds).
- African-Americans who have sought health information are more likely to report changing their behavior than others, with fully half (52 percent) saying they have done so (42 percent of Hispanics and 37 percent of whites).

<table>
<tr><td colspan="4">MSM General (Not prioritized)</td></tr>
<tr><td>Demographics:
MSM Public sex environments (cruising parks)</td><td>Setting:
Cruising parks and Public sex environments</td><td>Program example:
Hospers et al (1999) program in the Netherlands</td><td>Intervention type:
Street-outreach</td><td>Science/Theory:
1. Behavioral Intervention
2. Health Belief Model
3. Social Learning Theory</td></tr>
<tr><td colspan="3">Core Elements:
• Program trains volunteers to go into cruising areas to talk with cruising area visitors about the importance of safer sex.
• Volunteers give risk information, explain why safer sex is important, hand out brochure, condoms and lube.
• Volunteers do not talk to individuals who don't want the information.</td><td colspan="2">Findings:
Post –intervention survey of people who said had at least on conversation with a volunteer (conversation groupn=172) and those who hadn't been approached but would have had a conversation (no conversation control group, n=190). Conversation group had significantly higher condom use for insertive and receptive anal intercourse. MSM increased condom use more than MSMW. Conversations had no effect on intention to use condoms for anal intercourse.</td></tr>
</table>

MSM Youth (Not prioritized)

Demographics:	**Setting:**	**Program example:**	**Intervention type:**	**Science/Theory:**
MSM Young gay men ages 18-29	Community venues where gay men congregate Eugene, OR.	Mpowerment Project; Lifelong AIDS Alliance And POCAAN Seattle A CDC replicated Project	Community-level Social Marketing	1. Diffusion of innovation Model 2. Multifaceted Community Mobilation 3. Empowerment

Core Elements:

Based on theories of peer influence and diffusion of innovations,

A core group of young men design and run the intervention with input from a Community Advisory Board composed of "elders" from the HIV/AIDS, public health, gay and lesbian, and university communities. This engendered a personal commitment to HIV prevention, a sense of ownership of the prevention activities, and willingness to carry out the activities.

This multi-component intervention included 2 types of formal outreach, informal outreach, peer-led small groups and a small publicity campaign. One type of formal out reach activity took place at the Mpowerment Center (ideally the program has its' own space). It is consisted of safer sex promotional events embedded in a series of fun social activities. Informal outreach consisted of peer-initiated communications among friends about the need for safer sex. Small groups called M-groups, last about 3 hours and are designed to be fun and interactive. They served as entry into the project, address safer sex concerns and skills, and motivated participants to invite their friends. The small publicity campaign is aimed to reinforce the norms for safer sex and spread awareness of the Mpowerment Project.

Findings:

- After having received the intervention, men in the intervention community demonstrated significant reductions in unprotected anal intercourse with boyfriends, secondary partners, and men in general reduction. During the intervention interval, men in the control community did not demonstrate any significant reduction in unprotected intercourse.
- After the intervention, men reported fewer problems resisting unsafe sex when aroused.
- The intervention achieved it primary objective of significantly reducing unprotected anal intercourse but, despite high levels of awareness, it did not succeed in its efforts to change perceptions of the behavioral norms surrounding safer sex.

MSM Transgender (Not prioritized)				
Demographics: Transgender	**Setting:** CBO and University	**Program example:** University based human sexuality program with collaboration with a transgender and HIV/AIDS CBO Bockting WO, Rosser BRS, Coleman E (2000)	**Intervention type:** Group-level Street-outreach	**Science/Theory:** 1. Health Belief Model
Core Elements: • 4-hour workshop includes large and small group meetings with presentations, discussions, role playing, and exercises based on Health Belief Model, the eroticizing safer sex approach to HIV prevention, and principles of personal and community empowerment. Transgender sensitive audio-visual material used, sexually explicit materials used. Facilitated by Transgender peer educators. • Target materials and intervention to transgender community. • Recognize the diversity and uniqueness of community. • Affirm transgender identity. • Combat isolation. • Treat compulsive sexual behavior. • Provide ongoing support group. • Use confidential, secure location. • Provide opportunity to meet other transgender people. • Use street outreach and client incentives. • Develop targeted advertisement eroticizing safe sex.			**Findings:** Evaluation using a pre-, post- and 2-month follow-up test design showed an increase in knowledge an initial increase in positive attitudes that diminished over time. Due to small sample size(N=59) and limited frequency of risk behavior a significant decrease in unsafe sexual or needle practices could not be demonstrated. However, findings suggested an increase in safer sexual behaviors such as (mutual) masturbation. Peer support improved significantly.	

	HERR	HC/PI	CTR/PCRS
1.	A. Needle Exchange (SCO) B. Substance Abuse Treatment C. Prevention Case Management		A. CTR (high-risk) B. PCRS
2.	A. Individual Level Interventions B. Street/Community Outreach		
3.	A. Group Level Interventions	A. Mass Media & Other Media B. Social Marketing C. Hotline/Clearinghouse	

1.A: Health Education Risk Reduction – Syringe Exchange		Subpopulation
	Studies have demonstrated syringe exchange programs reduce the sharing of syringes. It is fully understood federal dollars are **NOT** permitted to support this type of intervention. However, it is recommended those communities who have other funding source and limited political barriers, establish a syringe exchange.	
Impact of HIV Risk and Infection and the Role of Prevention Services Watters, J.K., (1996). Journal of Substance Abuse Treatment, 13(5), 375-385 Point for Point (HIV AIDS Prevention Program Archives) Sociometrics August 2001	This intervention is centered on harm reduction principles. It does not condemn folks for their drug use, but it does not neglect the dangers associated with drug use. The strategy is to meet the drug uses on their terms to improve and proved them with health services	IDU and their non-injecting partners

1.B: Health Education Risk Reduction – Substance Abuse Treatment		Subpopulation
AIDS education for Drug Users: Evaluation of Short-term effectiveness. McCuster, J., Stoddard, A.M., et al. (1992) American Journal of Public Health, 83(10), 1463-6 Project SMART (HIV AIDS Prevention Program Archives) Sociometrics August 2001	This intervention was developed for use in short-term-treatment. There is as brief informational intervention that uses a cognitive development approach to get involveklent ion the presentation and discussions. Then there is an enhanced version that adds behavioral approach to prepare participants to reduce the chance of contracting HIV by using real life situations.	IDU and their non-injecting partners

1.C: Health Education Risk Reduction – Prevention Case Management (PCM)		Subpopulation
HIV Prevention Case Management Guidance and Literature Review and Current Practice. US Department of Health and Human Services. Public Health Service (1997)	The guidance defines and outlines developing, planning, and implementing prevention case management. PCM may be more costly than other HIV prevention activities, but cost effective because in emphasizes serving persons with particular difficulties changing behavior.	HIV + and their partners
2.A: Health Education Risk Reduction– Individual Level Intervention		**Subpopulation**
Outcomes of Intensive AIDS Education for Males Adolescent Drug Users in Jail. Magura, S., Kang, SY, Shapiro, MA (1994) Journal of Adolescent Health 15:457-463 (Sample SHARE intervention plan available)	This intervention is written as a group level intervention, but can be adapted to be an individual level intervention. The intervention seeks to change the risky behavior of incarcerated adolescent males between the ages of 14 and 19 years of age. Sessions would last approximately 45 minutes and use the "Problem Solving Theory" as guidance. An in-depth risk assessment along with the education is conducted.	Incarcerated adolescent males who share needles and have unprotected sex with multiple partners
2.B: Health Education Risk Reduction – Street/Community Outreach		**Subpopulation**
Outreach-Based HIV Prevention for Injecting Drug Users: A review of Published Outreach Data. Coyle, SL, Needle, RH et al (1998) Public Health Reports 113(1): 19-30	This published article discussed 36 outreach based HIV risk reduction intervention. The main focus was for IDUs not currently in drug treatment. About 2/3 of the outreach programs reviewed, had a C&T component attached. Areas covered during the outreach consisted of face-to-face risk reduction, prevention and services referral, condom distribution, bleach kits, and rehearsals of works cleaning and condom use. Findings concerning the interventions reviewed were: outreach is effective for reaching out of treatment IDUs, a significant proportion of the IDUs change their risky behavior, and changed behaviors are associated with lower rates of new HIV infection in IDUs.	All populations
3.A: Health Education Risk Reduction - Group Level Intervention		**Subpopulation**
15 Month Follow-up of women Methadone Patients Taught Skills to Reduce Heterosexual HIV Transmission. El-Bassel, N., Schillings, RF (1992) Public Health Reports 105 (5): 500-4 (Sample SHARE intervention plan available).	This group level intervention seeks to reduce sexual risky behavior and HIV transmission by teaching AIDS knowledge, sexual negations skills, and safer sex practices amongst the IDU population. The intervention worked with African American and Latino women in drug treatment. There were 5 sessions lasting approximately 2 hours each. There would also be a 7 and 15-month follow-up interview conducted.	African American and Latino women in drug treatment

A cognitive behavioral intervention to reduce HIV risk among active drug users. Rhodes, F., Wood. M.M. (1999). A paper presented at the 127th Annual Meeting of the American Public Health Association, Chicago, IL. Safety Point (HIV AIDS Prevention Program Archives) Sociometrics August 2001	This is a theory-based cognitive behavioral intervention designed to reduce HIV risk between crack and IDU not currently in treatment. There are three structural components 1) two sessions NIDA HIV C&T; 2) two group workshops sessions; and 3) one individual counseling session. In addition participants are encouraged to attend two-risk reduction luncheon. There are two planned support visits from outreach staff.	IDU and their non-injecting partners
3.A: Health Communication/Public Information – Mass Media & Other Media		**Subpopulation**
	No Interventions were reviewed. However, the media must be focused on the particular IDU population you are trying to reach and the risk behavior you are trying to change.	
3.B: Health Communication/Public Information – Social Marketing		**Subpopulation**
	No interventions were reviewed. However, the social marketing must be focused on the particular IDU population you are trying to reach and the risk behavior you are trying to change.	
3.C: Health Communication/Public Information - Hotline/Clearinghouse		**Subpopulation**
	Maintain a hotline and clearinghouse that will be accessible by anyone who wishes to receive either written and/or verbal information concerning HIV. The telephone line to reach this activity should be a toll free number.	All populations
1.A: Counseling, Testing, and Referral – High Risk		**Subpopulation**
Effects of Outreach Intervention on Risk Reduction Among IDU Neaihua A., Sufian M. et al (1990) AIDS Education and Prevention 2(4) 253-271	The purpose of this outreach intervention was to improve the level of risk reduction by providing information and anonymous HIV testing among IDUs. This intervention used ex-addicts as educators to provide HIV information, methods to prevent transmission, and an easy referral to HIV C&T for both the user and their partner. The premise was this intervention would reinforce the risk reduction already instituted, provide additional knowledge, and reach those who had not yet been exposed to education and C&T efforts.	All populations

1.B: Partner Counseling and Referral Service		Subpopulation
The Outreach assisted Model of Partner Notification with IDU. Levy JA, Fox SE (1998) Public Health Reports 113 (5-1): 160-9	This intervention consisted of two groups for those IDUs who test positive for HIV. The minimal group was strongly encouraged to inform their partners of possible exposure to HIV. The enhanced group was given a choice of informing their partner or have an outreach worker do the notification. Sixty of the sixth-three testing positive, provided the names of or some locating information for 142 partners they perceived as having been exposed in the past five years. Drug use accounted for 50%, sexual behavior accounted for 25%, and sex & drugs accounted for 25% of the named partners exposure. Outreach assisted notification was the preferred choice.	IDUs who test positive for HIV

	HERR	HC/PI	CTR/PCRS
1.	A. Community Level Intervention B. Group Level intervention C. Street/Community Outreach D. Prevention Case Management		A. CTR (high-risk) B. PCRS
2.	A. Individual Level Interventions	A. Mass Media & Other Media B. Social Marketing	
3.		C. Hotline/Clearinghouse	

1.A: Health Education Risk Reduction – Community Level Intervention		Subpopulation
The CDC AIDS Community Demonstration Projects Research Group (1999) Community-Level HIV Intervention in 5 Cities: Final Outcome Data From the CDC AIDS Community Demonstration Project. American Journal of Health, Vol.89, No3. Pages 336-345	This intervention was instituted to promote progress towards consistent condom and bleach use among the prioritized population. The flexibility of this intervention allows for easy adaptation to reach any population. Community members who encouraged behavior change among their selected population used role model stories along with condoms and bleach. The prioritized population selected in the demonstration cities were women who identify with sex trader behavior, IDUs & their female partners, heterosexually identified MSM, high risk youth, and residents in areas with high STD rates.	Multiple subpopulations

1.B: Health Education Risk Reduction – Group Level Intervention		Subpopulation
A Randomized Controlled Trial of an HIV Sexual Risk-reduction Intervention for Young African American women. DiClemente, R.J., and Wingood, G.M. (1995) The Journal of the American Medical Association, 274(16), pages 1,271-6 SISTA Project (HIV AIDS Prevention Program Archives) Sociometrics August 2001	This gender relevant and culturally appropriate social skills intervention emphasized ethnic and gender pride, sexual negation skills, proper condom use, and development of partner norms. Group sessions, lectures, role-play, and written material was used to effective carry out this intervention.	African American Women

Use of a Brief Behavioral Skills Intervention to Prevent HIV Infection Among Chronic Mentally Ill Adults. Kalichman, S.C., Sikkema, J., Kelly, J.A., Bulton, M. (1995) Psychiatric Services, 46(3), pages 275-280 Let's Chat (HIV AIDS Prevention Program Archives) Sociometrics August 2001	Using a behavior skills strategy, this intervention addresses risk reduction needs specifically for the mentally ill. There are four 90 minutes sessions that include AIDS prevention, role-play, practice condom use, discuss sexual pressure, and participate in other group activities.	Adults with chronic mental illness (the committee felt this would be good for non mentally ill clients as well).
The Effects of HIV/AIDS Intervention Groups for High Risk Women in Urban Clinics Kelly, JA, Murphy, DA et al (1994) American Journal of Public Health 84(12): 1918-1922	This intervention incorporated cognitive-behavior and risk reduction skills training to reach women at risk for HIV. There were five group sessions that focused of high-risk education, skills in condom use, sexual assertiveness, problem solving, risk trigger management, and support to assist with changes. The skills building component was a critical section in this intervention	Inner city women with multiple sex partners or partners of high risk persons
1.C: Health Education Risk Reduction – Street/Community Outreach		**Subpopulation**
	No interventions were reviewed for this intervention type. However, outreach efforts must be focused on the particular heterosexual population you are trying to reach and the risk behavior you are trying to change.	
1.D: Health Education Risk Reduction – Prevention Case Management (PCM)		**Subpopulation**
HIV Prevention Case Management Guidance and Literature review and Current Practice. US Department of Health and Human Services. Public Health Service (1997)	The guidance defines and outlines developing, planning, and implementing prevention case management. PCM may be more costly than other HIV prevention activities, but cost effective because in emphasizes serving persons with particular difficulties changing behavior.	HIV + and their partners

2.A: Health Education Risk Reduction– Individual Level Intervention		Subpopulation
Video-Based Sexually Transmitted Disease Patient Education: Its Impact on Condom Acquisition. O'Donnell, LN, San Doval, A., Duran, R., O'Donnell, C.(1995) American Journal of Public Health, 85(6) 817-822 (This is also a Sociometrics (HAPPA) intervention called "Doing Something Different")	This intervention used the theory of reasoned action. Here were three groups in this intervention. One received no information, one watched a video and another watched a film and had discussion surrounding the participants' needs. The greatest amount of change was noted in those who watched the video and then had discussion. The next was those who watched the video only. The least or no change was noted in those who didn't participate in either of the other groups.	African American and Latino men and women with multiple sex partners
Prevention of Heterosexual Transmission of Human Immunodeficiency Virus though Couple Counseling. Padian, NS, O'Brien, TR et al (1993) Journal of Acquired Immunodeficiency Syndrome. 6(9): 1043-8 (Sample SHARE intervention plan available)	This intervention seeks to promote and sustain behavior change among discordant couples. Couples are interviewed separately and together during each visit. They discuss safer sex, abstinence, refraining from unprotected sex, and nit entering into sexual relationship with new partners. They participate in role-play to build self-esteem, confidence, and male/female modes are used to educate them on HIV transmissions, contraception, and conception.	HIV + and their HIV negative partner
2.A: Health Communication/Public Information – Mass Media & Other Media		**Subpopulation**
	No Interventions were reviewed. However, the media must be focused on the particular IDU population you are trying to reach and the risk behavior you are trying to change.	
2.B: Health Communication/Public Information – Social Marketing		**Subpopulation**
	No interventions were reviewed. However, the social marketing must be focused on the particular IDU population you are trying to reach and the risk behavior you are trying to change.	
3.A: Health Communication/Public Information - Hotline/Clearinghouse		**Subpopulation**
	Maintain a hotline and clearinghouse that will be accessible by anyone who wishes to receive either written and/or verbal information concerning HIV. The telephone line to reach this activity should be a toll free number.	All populations

1.A: Counseling, Testing, and Referral – High Risk		Subpopulation
Evidence for the Effects of HIV Antibody Counseling and Testing on Risk Behaviors. Higgins, DL, C Galavotti et al (1991) Journal of American medical Association. 266 (17): 2419-2429	This article review research fro C&T procedures on multiple populations (IDU, MSM, pregnant women and "other" heterosexuals). While there were drastic behavior changes in some populations, there was little in others. Research suggests a number of psychosocial and environmental factors influence health risk reduction. HIV pre test and posttest counseling do not effect sustained behavior change. Referral to individual, group, or other HIV prevention activities will be necessary to achieve sustained behavior change.	All populations
1.B: Partner Counseling and Referral Service		**Subpopulation**
Partner Notification for Control of HIV: results After 2 Years of a Statewide Program in Utah. Pavia, AT, Bento, M. et al (1993) American Journal of Public Health 83:1418-24	**ALL** persons reported HIV+ were interviewed. Most of those diagnosed cooperated with the interviewers. Of the 308 index case clients, 244 cooperated and named 890 partners. Of those 154 had previously tested positive, 279 tested for the first time with 39 testing positive. Thorough contract tracing is necessary to reach those who may have been exposed.	Persons who test positive for HIV

INTERVENTIONS FOR HIV+

Interventions designed for HIV+ individuals are becoming a focus of many research projects. No one methodology has proven to be universally effective, but data continues to support the need to provide primary prevention services to HIV+ persons to promote reduction of risk behaviors, increase adherence to treatment/therapies and provide support for maintenance of behavioral changes.

Since the early 1990's, identification of potential participants in HIV+ services have come through early intervention services following counseling and testing and standard case management programs. A hybrid modality, labeled **Prevention Case Management (PCM)** emerged from these early efforts and became the subject of study, issuance of guidance by CDC (*Prevention Case Management Guidance, September 1997, CDC*).This guidance outlines the basic components of a PCM program and suggests the standards of practice for those activities. By definition, PCM should: 1) be considered primary prevention; 2) be most effective when applied as early as possible in the known HIV+ status; 3) be the result of self determination of the client; and, 4) have established high standards for professional practice similar to those in the social service, counseling and clinical psychological fields. The final outcome of PCM is the behavioral change of the client for HIV risk reduction. This intensive intervention goes far beyond the expectations of standard case management and it goal of assisting the client in accessing and utilizing appropriate resources and linkages. The identified CORE ELEMENTS and associated STANDARDS of a PCM program include:

1. RECRUITMENT and ENGAGEMENT
   Protocols for client engagement and related follow-up must be developed.
2. SCREENING and ASSESSMENT
   - PCM program staff must develop screening procedures to identify persons at highest risk for acquiring or transmitting HIV and who are appropriate for PCM;
   - All persons screened, including those who are not considered to be appropriate for PCM, must be offered counseling by the prevention case manager and referrals relevant to their needs.
   - Thorough and comprehensive assessment instruments must be utilized to assess HIV, STD, and substance abuse risks and their medical and psychosocial needs.
   - Case manages must provide a copy of a voluntary informed consent document for signature at the time of the assessment. This document must assure the client of confidentiality.
3. DEVELOPMENT OF A CLIENT-CENTERED PREVENTIO PLAN
   - For each client, a written Prevention Plan must be developed, with client participation, which specifically defines HIV risk-reduction behavioral objectives and strategies for change.
   - For person living with HIV and receiving antiretroviral or other drug therapies, the Prevention Plan must address issues of adherence.
   - The Prevention Plan must address efforts to ensure that a PCM client is medically evaluated for STDs at regular intervals regardless of symptom status.

- For clients with substance abuse problems, the Prevention Plan must address referral to appropriate drug or alcohol treatment.
- Clients must sign-off on the mutually negotiated Prevention Plan to ensure their participation and commitment.
- All Prevention Plans and associated documents will be maintained in a confidential manner.

4. HIV RISK-REDUCTION COUNSELING
   - Multiple-session HIV risk-reduction counseling aimed at meeting identified behavioral objectives must be provided to all PCM clients.
   - Training and quality assurance for staff must be provided to ensure effective identification of HIV risk behaviors and appropriate application of risk-reduction strategies.
   - Clients who are not aware of their HIV antibody status must receive information regarding the potential benefits of knowing their HIV serostatus.
   - Clients must be provided education about the increased risk of HIV transmission associated with other STDs and about the prevention of these other STDs.
   - PCM staff must develop a protocol for assisting HIV serpositive client in confidentially notifying partners and referring them for PCM and/or counseling and testing services.
   - For persons receiving treatment for opportunistic infections and/or antiretroviral therapy(ies), counseling supporting adherence to treatment and therapies must be provided.
5. COORDINATION OF SERVICES WITH ACTIVE FOLLOW-UP
   - Formal and informal agreements, such as MOU's, must be established with relevant service providers to ensure availability and access to key service referrals.
   - A standardized written referral process for the PCM program must be established.
   - Explicit protocols for structuring relationships and communication between case manages or counselors indifferent organizations is required to avoid duplication of services, i.e. co-management of clients in Ryan White Case Management and PCM.
   - Communication about an individual client with other providers is dependent upon obtaining a written, informed consent and release of information from the client.
   - A referral tracking system must be maintained.
   - Annual assessment of relevant community providers with current referral and access information must be maintained.
   - A mechanism to provide client with emergency psychological or medical services must be established.
6. MONITORING AND ASSESSMENT OF CLIENTS' NEEDS and PROGRESS
   - Prevention case managers must meet on a regular basis with clients to monitor their changing needs and their progress in meeting HIV behavioral risk-reduction objectives. Individual meetings with a client must be reflected in the client's confidential progress notes.
   - A protocol must be established defining minimum, active efforts to retain clients. That protocol should specify when clients are to be made 'inactive.'

7. DISCHARGE FROM PCM UPON ATTAINMENT and MAINTENANCE OF RISK-REDUCTION GOALS.
   - A protocol for client discharge must be established.

Additional standards around staff qualifications, program coordination, quality assurance, and, ethical and legal issues, including confidentiality, voluntary and informed consent, cultural competence, professional ethics, discharge planning and duty to warn, are also included.

Other interventions have begun to emerge from the literature and practice. In 1998, CDC funded 5 demonstration projects in 5 major cities. These are now part of the Positive Images social marketing programs in Boston, San Francisco and Los Angeles. They can be reached on the web at www.hivstopswithme.com (Senterfitt, WR, 2000) Another media project was coordinated by the AIDS Action Committee in Boston. (AIDS Action Committee, 1996)

Here in Washington, the University of Washington School of Social Work (Rosemary Ryan) has utilized motivational interviewing in Project SHAPE and HAPDEU is presently providing the services and technical assistance for a group-level intervention called Positive Power. Both of these projects were highlighted last year in our effective interventions presentations.

There are emerging programs for IDUs, including VOICES, a mentor based program in Los Angeles. Heterosexual men and women are being addressed in the Women Alive (L.A.) formative research project. These, and other projects can be reviewed on the www.caps.ucsf.edu website.

Couples counseling (Padian etal 1993 and Remian, RH, 1997) has proven to be a effective intervention for discordant couples. The OASIS model for identification, recruitment and testing of potentially HIV+ individuals is the basis for the KNOW YOUR STATUS prject presently being implemented in eastern Washington and has proven very successful in its original form in Los Angeles. Linking STD prevention services to the HIV+ clients has also been a focus of several projects. Characteristically, most of these projects have been multi-session, individual or group level interventions with strong behavioral and referral components. All encompass harm reductions information and help clients set and maintain goals for risk-reduction.

Without clear evaluation and research data from these various projects and programs, it is difficult to recommend a prioritized list of effective interventions for planning groups to consider. With all of the regional planning groups identifying HIV+ individuals and the partners as priority populations, it is important that there be some discussion of what seems to be the best approach within the limitations, capacities and needs for HIV+ related interventions.

Some other **questions** that might be discussed by the SPG might include:

1. Collaboration efforts between care and prevention services. How best can harm reduction and/or risk-reduction messages become part of the process?
2. What training for case managers and prevention workers should be recommended?
3. Should the SPG recommend that prevention services to HIV+ be reviewed in each region?
4. How best can these efforts also focus on the partners of HIV+ people?

The following is a partial **bibliography** (borrowed from the CAPS Factsheet on "What is Needed by HIV+ Persons" and includes the references in this report.

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ATTACHMENT 3A

DRAFT OF PRIORITIZED POPULATION NEEDS ASSESSMENT GUIDANCE

Washington State
HIV Prevention Statewide Planning Group

Prioritized Population Needs Assessment Guidance

2002

Table of Contents

This guidance document was developed for the Statewide HIV Prevention Planning Group.

The document was drafted by Amy Manchester Harris, MPA of the Department of Health's Infectious Disease and Reproductive Health (IDRH) Assessment Unit and endorsed by the Statewide HIV Prevention Planning Group on March 28th, 2002.

Also developed were two companion pieces to the PPNA - guidance on Key Informant Interviewing and Focus Groups. Contained in these documents is more information about these two methodologies, protocols and questions.

What is Prioritized Population Needs Assessment?

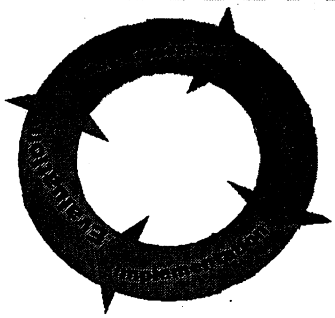
Prioritized Population needs assessment is the process for ***obtaining and analyzing information to determine the current status and service needs*** of a specific targeted population (e.g., MSM, IDU/MSM). This is done within a defined geographical area such as a regional planning area, county or city.

In HIV Community Planning the Prioritized Population Needs Assessment (PPNA) is conducted to balance information gathered through the Epidemiologic Profile, the Community Resource Inventory, and the Statewide HIV Prevention Planning Group Effective Interventions Matrix.

How is PPNA Different from Program Evaluation?

Program evaluation examines past activities of a program or agency and looks at how effective they have been at meeting the program's goals.

Needs assessment focuses on future activities by providing information on where the program or resources need to be targeted.



Why Should HIV Prevention Planning Groups do PPNA?

Throughout Washington, there are populations of individuals at high risk for HIV because of their behaviors. For some of these populations there is no epidemiologic or other data available. PPNA information can assist in understanding a population's needs or risks.

PPNA can also help answer if an intervention is appropriate for/applicable to Washington State's Prioritized Populations. Feedback from the populations to be targeted through the intervention may help to provide information on/or if the intervention(s) will succeed in the identified community.

According to the Community Resource Inventory, there are prioritized populations that do not receive needed prevention services. The specific barriers that prevent their access to these services have not been determined.

Elements of a Comprehensive PPNA

A comprehensive PPNA has the following three key elements:

- ☑ *Targets High-Risk Populations or Sub-Populations*
  Identified in the epidemiologic profile or by the regional or state planning group as populations for whom there is not much information;

- ☑ *Describes Behaviors/Prevention Needs*
  Provides information on HIV risk behaviors or prevention needs of prioritized populations;

- ☑ *Describes Prevention Needs that are being Met*
  Provides information on the prevention needs that are being met and which interventions are working (or not working) for the prioritized populations.

PPNA data may describe the extent to which specific prioritized populations:

- Are aware of HIV transmission methods and high risk behaviors;
- Are engaging in high risk behaviors;
- Have been reached by HIV prevention activities;
- Are likely to participate in HIV prevention activities;
- Have experienced barriers that make it difficult to be involved in HIV prevention initiatives; or
- Have been reached through outreach strategies and/or interventions that have overcome barriers to HIV prevention.

How Can PPNA Data be used in the Prioritization Process?

Before engaging in any data collection activity, it is important to identify what the desired outcome is, and how the data to be collected will be used in the prioritization process

Below are several examples of ways that prioritized population needs assessment data could be beneficial in the prioritization process:

- *Identification of Additional Sub-populations' Risks*
  As the Regional Planning Groups develop their lists of at-risk sub-populations under the major behavioral risk categories, there may be sub-populations they suspect are participating in high risk behaviors, but for whom they only have

anecdotal information. PPNA could be done to get more information about the risk behaviors of these sub-populations.

- *Identification of Sub-populations' Prevention Needs*

  Although the State/Regional Planning Groups have provided information on effective interventions for the broader behavioral risk categories, interventions for sub-populations may not be available. PPNA conducted with sub-population members may provide information about *how they receive prevention messages and what interventions they think would be most effective.* This information could augment effective intervention prioritization that reflects the regional need.

- *Identification of Barriers to Prevention*

  The Community Resource Inventory (CRI) describes populations that are reached or targeted through current prevention activities. PPNA can provide feedback from clients and providers on prevention access barriers.

Developing a Plan for PPNA: Questions to Ask

A comprehensive PPNA requires planning, time, and resources. An assessment plan may be developed to fit into a two-year planning cycle. Each year would include some form of assessment activity (e.g., focus group). How it was going to be conducted and to which population would be determined within the two-year plan.

Below are some questions to ask when beginning a PPNA plan.

Q What are the specific desired outcomes of the year's PPNA?

- To be used for prioritization process
- To understand sub-population's risk/behavior
- To understand specific prevention needs
- To understand barriers experienced by sub-populations

Q What resources are available to support the PPNA effort (funding, staffing, etc.)?

- A well-designed PPNA takes time and money to implement.

Q Will there be any collaborative effort with Ryan White CARE Act needs assessment activities?

Q How will roles for conducting the PPNA be divided?

Q What is the timeline for completion of the PPNA?

Prioritized Population Needs Assessment: Step-By-Step

1. **Identify Information Needed** – It is important to know how the information will be used in the prioritization process and what type of information is needed (e.g., more information about sub-population's risk and/or barriers to services).

2. **Review Available Data** – Some regions have already done needs assessments or have other existing sources of data (e.g, Consortia data). It is important to identify these so that efforts aren't duplicated.

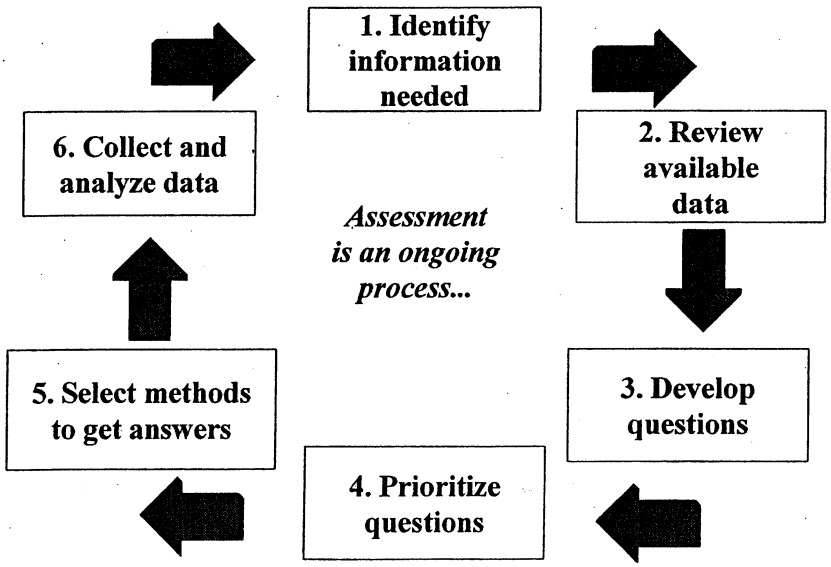
3. **Develop Questions** - This is one of the most important elements of a PPNA. Refer to the gap analysis for possible questions. PPNA key informant and focus group companion pieces for more information on questions.

4. **Prioritize Questions** – Very often questions will come up about information that would be interesting to know. These must be differentiated from the questions that will get the information that you need to know.

5. **Select Methods to Get Answers** – This guidance recommends the use of key informant interviews as the first choice for reaching selected audiences. Key informant interviews can be utilized in a rural or urban area to collect in-depth information about client needs. Focus groups would be the second recommend method. If the use other methods is being considered, please consult with the DOH IDRH Assessment Unit, (360) 236-3417.

6. **Collect and Analyze Data** – Data should be collected uniformly with any method selected (e.g., focus group or key informant). Qualitative data can be tricky to analyze. Any data that is collected needs to be compared with other data sources (e.g., epidemiological data) to determine gaps and/or inconsistencies in the data. Technical assistance is available. References are listed at the end of this document.

Prioritized Population Needs Assessment Model



What are the Expectations for Conducting PPNA at the Regional Planning Level?

Assessment of the prevention needs of prioritized populations is an ongoing process. *It is recommended that every year, each Regional Planning Group choose at least one of their high prioritized sub-populations* for which supplementary data are needed and complete the prioritized population needs assessment(s).

Identify Information Needed

Most PPNA are conducted to provide information not captured anywhere else for the community planning prioritization process. Information gathered is about the sub-population's risk and/or barriers to services.

Review Available Data

Some sub-populations may be impacted by other social service agencies and there may be needs assessment data available. This information may provide a foundation to ask additional questions. It is important not to duplicate efforts.

Depending on your prioritized population, you may want to consult other sources, such as:

- Epidemiological Profile
- Community Resource Inventory
- HIV Consortia Needs Assessment for information on HIV positive individuals
- Community-based organizations providing interventions to the same people that have conducted evaluation components (e.g., Friend to Friend Project).
- Substance use data related to your area that is not reflected in the epidemiological profile (e.g, hospital reports of drug overdoses, arrest records for drug use).

Some data are collected in a way that can be very difficult to interpret, and may take the skills of a trained assessment person to understand. Technical assistance may be obtained from the DOH IDRH Assessment Unit, (360) 236-3417.

PPNA and Human Subjects Review

Research involving human subjects sponsored by the DOH requires prior review and approval by the DSHS/DOH Human Research Review Board (HRRB).

The primary intent of the needs assessment determines whether it qualifies as research which requires review by the HRRB.

Needs assessments are research if the:

- Primary intent is to produce generalizable knowledge to improve public health practice;
- Intended benefits of the project may or may not include study participants, but always extend beyond the study participants, usually to society; and
- Data collected exceed the requirements for care of study participants or extend beyond the scope of the activity.

Needs assessments are not research if the:

- Primary intent is to identify and control a health problem or improve a public health program or service;
- Intended benefits of the project are primarily or exclusively for the participants or the participants' community;
- Data collected are needed to assess and/or improve the program or service, the health of the participants or the participants' community; and
- Knowledge that is generated does not extend beyond the scope of the activity.

Prioritized Population Needs Assessments are almost always non-research activities. In some cases, however, data collected for non-research purposes later may be used for research that requires HRRB review. If you have questions about whether your PPNA may involve research, contact HRRB staff at (360) 902-8075. Information about the review process is found at the HRRB website: http://www-app2.wa.gov/dshs/rda/hrrb/human_research.htm.

Developing and Prioritizing Questions

Developing and prioritizing questions is one of the most important elements of a PPNA. All HIV community planning groups are funded in whole or part with federal or state funds that are provided through the State. The Department of Health has developed a set of core questions to be utilized in PPNAs conducted in Washington State.

Uniformly applied questions will allow for the establishment of a baseline of statewide information on prioritized populations' needs. There may also be a need to add additional area specific questions. The IDRH Assessment Unit can assist with their development.

Please refer to the PPNA Key Informant and Focus Group Protocols companion pieces, for more information.

Select Methods to Get Answers

There are several ways that information on populations needs can be collected. For HIV Prevention PPNA, DOH recommends the use of key informant interviews and/or focus groups.

There are several other methodologies for gathering needs assessment information. Other methods may be utilized with prior review and coordination with DOH.

Some interventions may also come with materials to be used in conducting needs assessment such as HAPPA materials found in the effective interventions kits endorsed by the Centers for Disease Control and Prevention (CDC) and available commercially from Sociometrics Corporation.

These commercial materials should be carefully reviewed and questions directed to DOH for technical assistance and adaptation.

To comply with CDC Program Review Panel requirements, all methods or materials must be provided to DOH for a review, prior to use. Contact the Assessment Unit at 360-236-3417

Key Informant Interviews

The key informant interview is a qualitative method of gathering information. Key informant interviews are conducted on persons who are 'knowledgeable' about the HIV prevention needs for a particular population or group of people.

A key informant interview is an in-depth guided interview that has been scripted (each person interviewed is presented with the same questions). An interview normally is conducted for no longer than an hour.

Key informant interview information can be supplemented with focus group information. Key informant data can also assist in the development of topics for focus groups or other assessments.

Key Informant Interviews:

- Are good qualitative measures as they provide good in-depth data and allow for follow up
- Can be used to gather information from hard-to-reach populations

- May be effective (in large numbers) for quantitative measures
- Provide in-depth information
- Result in identifying key questions for focus groups and surveys

Information taken from these groups cannot be generalized to a larger population. The information gathered should represent the varied needs within the community.

What is Qualitative Data?

It examines people, events, processes primarily through words and trends.

It focuses on group's dynamics, meaning and context of what was said by the participants. It cannot be statistically analyzed.

Training Needed

Conducting effective key informant interviews takes a skilled interviewer. The interviewer should have knowledge of HIV prevention services and must adhere to an established standardized interview format. Questions must be asked in a non-biased manner.

For more information refer to the: PPNA Key Informant Protocol and Questionnaire available through your regional coordinators or from DOH, (360) 236-3417.

Focus Groups

Focus groups are a valuable tool to "gain insight into how people think and learn about their personal life situations." (Morgan, 1993)

They are an in-depth guided discussion led by a trained moderator. Focus groups are conducted for research or program improvement and are focused on a particular topic of inquiry; and have a framework of questions related only to the topic.

Focus groups are not meant to moderate group decision-making, team building or to be used to create a public image of listening (Morgan, 1993).

Focus groups are used to:

- Generate ideas for a program, campaign or materials;
- Pretest educational or promotional concepts, messages and materials;
- Improve a product or service by understanding people's attitudes and needs; and,
- Identify issues for quantitative research or clarify findings.

Morgan DL. (1993) *Successful Focus Groups: Advancing the State of the Art.* Thousand Oaks: Sage Publications

Common Misconceptions about Focus Groups

There are many misconceptions about Focus Groups. The most common being that focus groups are:

- *Fast, Easy and Inexpensive*
  Focus groups take time and resources to plan, recruit, conduct and then analyze the data. Focus group must be planned with clear expectations of the data wanted from the participants and a clearly defined prioritized population.

- *People sitting around talking*
  There is a difference between a focus group and a group discussion. A group discussion includes people who are from different levels within the topic area. Many times group discussions are unfocused and cover a broad topic. They can consist of a series of questions asked of each participant (serial interviewing).

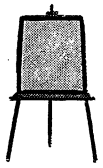
  A focus group recruits persons from the prioritized population who have not been intimately involved in with the topic area. These people have a common link and are reflective of the community you are trying to reach. The discussion is a structured group interview.

- *Sources of Quantitative Data*
  Focus groups do not collect quantitative data. *They can however, provide very useful qualitative data.* They examine people, events, processes primarily through words and trends. It focuses on group's dynamics, meaning and context of what was said by the participants. It cannot be statistically analyzed.

- *Not Appropriate for Sensitive Topics*
  Research on focus group methodology has found that people "... may be more, rather than less, likely to self-disclose or share personal experience in groups rather than dyadic settings." (Barbow and Kitzinger, 1999) People may be more likely to disclose or discuss information openly with people they perceive to be like them.

Training Needed

Focus groups require skilled facilitation. Someone trained in focus group facilitation should conduct them. The most important skill a facilitator must have is the ability to identify subtleties, and remember points to come back to during the session. There are training materials available to assist in conducting focus groups.



For more information refer to the: PPNA Focus Group Protocol and Questionnaire and/or see the resources section of this guidance page 12.

Collecting and Analyzing the Data

It is important to consider how the data will be collected and analyzed during the PPNA planning process, prior to the implementation of the PPNA.

- How will the data be utilized?
- Who will be responsible for collecting the data?
- Will the data be collected in a uniform manner?

- How will the data be analyzed?
- Where will the data be housed?

> If you have resources within your agency on data analysis it may be useful access those in the planning stages of your needs assessment to see what assistance they can provide. Also they can assist in making sure the data collected will actually answer the questions you have for the target population(s).

Barbow RS, Kitzinger J. (1999) *Developing Focus Group Research: Politics, Theory and Practice.* Thousand Oaks: Sage Publications.

Ensuring Confidentiality

Data Collected

Any information collected during the PPNA process that personally identifies an individual (e.g., name, address etc.) is confidential information. Identifying and locating information must be separated from the individual's demographic information and responses and stored in a secure locked location. All identifying information must be destroyed as soon as it is no longer needed.

Discussion of Data

Any discussion of data should not include use of specific participant's name or other information that may lead to identification of the participant. All persons working on the needs assessments should sign a confidentiality statement or oath stating that they will not discuss information gathered. A sample confidentiality oath can be obtained from the IDRH Assessment Unit by calling (360) 236-3417.

Focus Groups
Individuals who participate in focus groups should be informed before the session starts that, while everyone is asked not to share the discussion outside the focus group, the confidentiality of what they say in the group cannot be guaranteed.

Data Storage
After completion of the PPNA, all data collected (surveys, notes, cassette tapes etc) should be kept in a locked file cabinet. Only staff involved in the process should have access to the information.

Every individual with access to confidential information must take personal responsibility for its protection. Community planning activities that collect information are bound by Washington State's confidentiality laws (RCW 70.24.105).

Violation of any provision is a gross misdemeanor punishable by imprisonment for up to one year. In addition, violation may result in civil liability of up to $10,000 for reckless or intentional breech.

Where can we seek further Assistance/Guidance/Information?

Much of the material used for this section of the prioritized population needs assessment guidance was adapted from:

Assessing the Need for HIV Prevention Services:
A Guide for Community Planning Groups

Academy for Educational Development's Center for Community-Based Health Strategies. (202)884-8000

Single copies of this publication are available from the National AIDS Clearinghouse at no cost. Additionally, the AIDSNET Coordinators will have copies of this document.

Good Questions Better Answers:
A Formative Research Handbook for California HIV Prevention Programs

California Department of Health Services Northern California Grantmakers AIDS Task Force. For copies call California AIDS Clearinghouse at (213) 845-4180.

In addition, assistance/guidance/information may be available from: Statewide Planning Group members, AIDSNET Coordinators, Department of Health staff, and/or staff at local health departments and community-based organizations.

PPNA Key Informant and Focus Group Protocols

Protocols for the conducting Key Informant and Focus Groups are available through the Regional Coordinator's office or the State Department of Health, Assessment Unit. Call your regional coordinator or DOH at (360) 236-3417 for copies or assistance.

ATTACHMENT 3B

DRAFT OF PRIORITIZED POPULATION NEEDS ASSESSMENT – FOCUS GROUP PROTOCOL

Washington State
HIV Prevention State Planning Group

Prioritized Population Needs Assessment Focus Group Protocol

This is a companion piece to the HIV Prevention State Planning Group's Prioritized population Needs Assessment Guidance

This document, developed for the Statewide HIV Prevention Planning Group, is one of two companion pieces to the Prioritized Population Needs Assessment Guidelines.

The document was drafted by Amy Manchester Harris, MPA, of the Department of Health Infectious Disease and Reproductive Health (IDRH) Assessment Unit.

For questions or technical assistance contact your regional coordinators and/or the IDRH Assessment Unit at (360) 236-3417.

TABLE OF CONTENTS

What is Prioritized Population Needs Assessment?

Prioritized Population Needs Assessment is the process for ***obtaining and analyzing information to determine the current status and service needs*** of a specific targeted population (e.g., MSM, IDU/MSM). This is done within a defined geographical area such as a regional planning area, county or city.

In HIV Community Planning, the PPNA is conducted to provide data on unmet needs for the gap analysis (refer to the *Washington State HIV Prevention Gap Analysis Model Guidance*), and to balance information gathered through the Epidemiologic Profile, the Community Resource Inventory, and the Statewide HIV Prevention Planning Group Effective Interventions Matrix.

Refer to the *State HIV Prevention Planning Group Prioritized Population Needs Assessment Guidance* for additional information. Copies are available through your regional coordinator or from the Department of Health, HIV Prevention Unit (360) 236-3434.

What is a Focus Group?

Focus groups are a valuable tool to "gain insight into how people think and learn about their personal life situations." (Morgan, 1993)

Focus groups are in-depth guided discussions led by a trained moderator. Focus groups are conducted for research or program improvement, are concentrated on a particular topic of inquiry, and have a framework of questions related only to the topic.

Focus groups are useful for:

- Generating ideas for a program, campaign or materials;
- Pre-testing educational or promotional concepts, messages and materials;
- Improving a product or service by understanding people's attitudes and needs; and,
- Identifying issues for quantitative research or to clarify findings.

What is the Difference Between Qualitative and Quantitative Data?

Both examine people and events, but they are different in how they are conducted and in how data are analyzed.

Qualitative data utilizes a process that is primarily through words and trends. It focuses on a group's dynamics, meaning and context. It cannot be statistically analyzed.

Quantitative data is collected in a way that can be expressed in numbers and analyzed statistically. These include such things as surveys.

Common Misconceptions about Focus Groups

Focus groups are not meant to moderate group decision-making, team building or to be used to create a public image of listening (Morgan, 1993). Some common misconceptions about focus groups are:

- **Fast, Easy and Inexpensive**
  Focus groups take time and resources to plan, recruit, conduct and then analyze the data. Focus group must be planned with clear expectations of the data wanted from the participants and a clearly defined prioritized population.

- **People sitting around talking**
  There is a difference between a focus group and a group discussion. A group discussion consists of a discussion of people who are concerned or involved in the topic issue. Many times group discussions are unfocused and on a broad topic. They can consist of a series of questions asked of each participant (serial interviewing).

  A focus group recruits persons from the prioritized population who have not been intimately involved in with the HIV planning process or in program delivery. These people have a common link and are reflective of the community you are trying to reach. The discussion is a structured group interview.

- **Quantitative data**
  Focus groups do not collect quantitative data (statistical data, projections). *It can however, provide very useful qualitative data.* It examines the participants' opinions about people, events, processes primarily through words and trends. It focuses on group dynamics, meaning and the context of what was said by the participants. It cannot be statistically analyzed.

- **Sensitive topic are difficult in focus groups**
  Some people believe that you cannot use focus groups for sensitive information. Actually, research has found that people "... may be more, rather than less, likely to self-disclose or share personal experience in groups rather than dyadic settings." (Barbow and Kitzinger, 1999) It also found that in fact people may be more likely to disclose or discuss sensitive or personal information openly with other group members they feel are like themselves.

PPNA and Human Subjects Review

Research involving human subjects sponsored by the DOH requires prior review and approval by the DSHS/DOH Human Research Review Board (HRRB). Prioritized Population Needs Assessments are almost always non-research activities. In some cases, however, data collected for non-research purposes later may be used for research that requires HRRB review.

The primary intent of the needs assessment determines whether it qualifies as research which requires review by the HRRB.

Needs assessments are research if the:

- Primary intent is to produce generalizable knowledge to improve public health practice;
- Intended benefits of the project may or may not include study participants, but always extend beyond the study participants, usually to society; and
- Data collected exceed the requirements for care of study participants or extend beyond the scope of the activity.

Needs assessments are not research if the:

- Primary intent is to identify and control a health problem or improve a public health program or service;
- Intended benefits of the project are primarily or exclusively for the participants or the participants' community;
- Data collected are needed to assess and/or improve the program or service, the health of the participants or the participants' community; and
- Knowledge that is generated does not extend beyond the scope of the activity.

If you have questions about whether your PPNA may involve research, contact HRRB staff at (360) 902-8075. Information about the review process is found at the HRRB website: http://www-app2.wa.gov/dshs/rda/hrrb/human_research.htm.

Three Core Elements to Conducting Focus Groups

There are three core elements to conducting a focus group, each requiring prior planning. A successful focus group process is based on clear expectations for the information wanted and has been well planned.

Three core elements:

- **Recruitment**
- **Question Development**
- **Data Analysis**

Focus Group Recruitment

Deciding who should be at a focus group is an important element to conducting a successful focus group. Many times, the focus group organizer(s) are quick to jump to developing their questions and do not spend the time necessary to clearly identify their prioritized population and to develop a strong recruitment plan.

Step One: **Clearly define what you need to know**

It is important to clearly know the broad information you want to gather about a particular prioritized population. Why are you having a focus group?

Examples:
Why are the people accessing your program not interested in the group-level intervention you offer?

In the clients' view, what are important elements to include in an HIV prevention intervention?

Step Two: **Clearly define your prioritized population**

It is important to clearly define your prioritized population, so that you have the right people at the table for the discussion. Who do you need to talk to in order to gather the information needed to answer your question(s)? In marketing terms this is called segmenting.

Example:
Prioritized population: MSM

What are the *important similarities and differences* your MSM audience should share?

- Race/ethnicity?
- Age?
- Economic status?
- Life experiences (e.g., incarcerated, HIV+, mental illness, substance use)?
- Certain shared activities (e.g., use internet to attract sex partners)?
- Frequent similar places (e.g. bathhouse, social events, HIV prevention activities)?
- Have certain risk behaviors (anonymous sex partners)?
- Located in a particular area (Yakima Valley, 1st Ave)?
- Utilize/underutilize a particular service (counseling/testing or care services)?

If participants share basic similarities (e.g., lifestyle – IDU), they may feel more comfortable sharing their perceptions and experiences among perceived peers.

Step Three: **Consider the needs of your participants**

To maximize your prioritized populations' participation, you will need to consider their needs. Will they feel comfortable attending your focus group?

- **Confidentiality**
  If participants believe that their confidentiality will be protected they are more likely to agree to participate in a focus group and be more sharing of their opinions during the focus group. See confidentiality section for information on Washington State confidentiality laws.

- **Physical Location**
  Conducting the focus group in a neutral location can assist participants to be more comfortable in attending because it is a setting they are familiar but maintains confidentiality (this maybe a church or building familiar to the participants but not associated with HIV/AIDS activities). A threatening location can translate into a negative feeling that may bias or limit participation.

Avoid Piggybacking
To maximize resources, organizations will piggyback a focus group with other activities, such as a conference or support group. This could jeopardize the quality of the focus group data.

Participants and participation may be influenced by the climate (speakers, presentations or other participants) of the conference or meeting. (Morgan, 1993)

Using pre-existing groups can also be problematic. The group may not reflect diversity within the prioritized population. Group dynamics may have developed which could impede open conversation/disclosure. Avoid conducting focus groups within pre-existing groups. There may be some instances where a pre-existing group maybe the only way to get to hard-to-reach populations. Please consult the state Assessment Unit prior using pre-existing groups.

- **Time**
  The average focus group meets for 1½ to 2 hours. Before establishing the time for your focus group it is important to look at the needs of the participants you are recruiting into your focus group.

  - What are their work/activities practices?
  - Do they have children? Will childcare be needed?
  - Are there language needs?

- Is an incentive needed? (see section on incentives, for more information)

Group Size
Typically, focus groups have 8 to 10 participants. It is not recommended to have less than 6 or more than 12. Too small of a group could cause problems with the quality of data and too large of a group may be hard to manage. It may be appropriate to over-recruit for prioritized populations who are more likely to not show up to scheduled events.

Step Four **Develop recruitment methodology and participant screening tool**
Once you have decided the criteria for your focus group, you must decide how and where you will recruit focus group participants.

If you are planning to make program improvements or funding decisions based on focus group data you need to make sure that you have the right people at the table. A well-thought out recruitment plan is essential.

Recruitment Methodology
To obtain a good sample of your prioritized population you must recruit from locations that your prioritized populations are found.

Avoid recruiting the "usual suspects," those you always go to for advice and/or who are involved in HIV prevention activities within your agency or community.

Many times when people start to recruit for focus group they seek people who are known to them and are easily accessible. Although this seems like an easy way to get participants into a focus group, there are problems with this type of recruitment. It is important not to assume that these 'insiders' have the same needs or opinions as 'non-users' (Morgan, 1993).

Participant Screening Tool
Once the criteria have been established for your prioritized population, a tool should to be developed to screen and recruit potential participants.
The recruitment tool is normally a set of close-ended questions that obtain basic information about potential participants.

- ✓ Do they reside within your city/county?
- ✓ What is their age?
- ✓ Are they over 18 years of age?
- ✓ Are they part of the audience you are trying to reach?
- ✓ Are they willing to participate?

IMPORTANT

It is important for recruited participants to *fully understand* that they are committing to discuss a particular topic within a group setting.

It is unethical to mislead or coerce focus group participation such as misrepresent the intentions or withhold services for persons who do not attend.

Potential Participant Knowledge

Think about what information you would need to know in order to make an informed decision on participation in a focus group. These may be things, like:

- An explanation of what type of information is desired by the agency conducting the focus group;
- Information on the agency conducting the focus group; and
- Information on why it is important for 'ME' to participate in the focus group.

➡Refer to the *Focus Group Tools* section for an example recruitment tool.

Developing Focus Group Questions

Once you have defined what information you want from your prioritized population and who they are, you are ready to move question development.

Most focus groups utilize a pre-defined script. Adherence to this script is important to obtain the desired information. This is especially important if multiple focus groups are being conducted with the same prioritized population. The script includes an introduction, rapport-building exercise, in-depth discussion questions and conclusion.

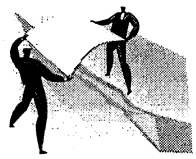
The in-depth questions section normally includes 8 to 10 well-developed questions directly related to the information wanted from the prioritized population. Along with these base questions, follow-up probe questions are developed to ensure that the participants' responses are fully understood. You may or may not be able to get through all of your questions with probes and discussion. For this reason make sure you prioritize the questions so that you make sure you get the core information from your focus group.

Well-written focus group questions are phrased as concrete questions. Abstract or philosophical question may be hard for participants to respond to and difficult to analyze. Questions should be straightforward; the moderator should not have to explain the intent of the question.

During the focus group participants *should not* be asked to solve problems (e.g., of the particular program), or be used by participants for personal theory or support. Focus group participants *should* be asked to identify problems/needs.

Developing Questions for the Gap Analysis

PPNA in HIV prevention planning is normally conducted to collect information on the unmet needs of a prioritized population to be folded into the gap analysis.



Why is a gap analysis conducted in HIV prevention planning?

Gap analysis is conducted to identify met and unmet needs within a prioritized population. Identification of those needs assists in prioritizing prevention funds, prioritized populations to work with and interventions to be utilized. Needs assessment data help to determine the current status of prevention needs and services.

What's an Unmet Need?

HIV prevention services for a specific prioritized population that are not currently being addressed through existing HIV prevention services/activities, either because no services are currently available or because available services are either inappropriate or inaccessible to the prioritized population.

-Washington State HIV Prevention Planning Gap Analysis Model

The Washington State HIV Prevention Planning Gap Analysis Model focuses on three areas of information to assess a community's HIV prevention needs:

- **Knowledge of:**
  - ✓ The fact that HIV is a potential life threatening disease
  - ✓ Behaviors that transmit HIV
  - ✓ HIV status
  - ✓ HIV Prevention
  - ✓ Where to go for services, resources and social support
  - ✓ How to access culturally and linguistically appropriate competent interventions

- **Attitudes and Behaviors**
  - ✓ Perceived susceptibility and vulnerability
  - ✓ Motivation, intention, and commitment to reduce high risk behaviors and increase low risk activities
  - ✓ The self-esteem and confidence that one can utilize risk reduction behaviors consistently and under a variety of circumstances
  - ✓ Awareness of social influence and social norms that impact HIV transmission
  - ✓ Sense of personal responsibility to not transmit HIV to others

- **Behavioral/Skills**
  - ✓ Identification of high risk behaviors and ability to assess own risk of infection
  - ✓ Use of risk reduction practices
  - ✓ Use of communication skills that reduce HIV transmission
  - ✓ Use of problem solving and decision making skills that reduce HIV transmission

- ✓ Level of peer support for behavior change
- ✓ Level of norms regarding acceptability of insisting on safer sex
- ✓ Level of maintenance of consistent behavior change

Getting to the Unmet Need

Within each of these three focus areas and for each sub-question (listed previously), information about access and resources is assessed both to identify if there is an unmet need and to prioritize resources. Needs assessment and community resource information (CRI) data are used to complete the gap analysis grids (refer to the Attachment section for copies of the gap analysis grids).

Assessment questions gathered from the needs assessment:

- How much information is possessed by the prioritized population?
  e.g., knowledge of how HIV is transmitted
- How many resources, services and policies outside of your direct control affect the need?

Assessment questions gathered from the Community Resource Inventory:

- How do existing HIV resources address the prevention need?
- If funding was lost, would it impact the prevention need?

Final conclusion questions from all information gathered:

- Is the prevention need unmet?
- What is the priority of funding interventions based on the prevention need?

Once the needs assessment has been conducted and the resulting data has been folded into the gap analysis model, the gap analysis is complete. This should provide a clear picture of the HIV prevention needs (both met and unmet) in your RPG service area.

Getting help with developing the right questions for your prioritized population

Assistance in developing questions can be obtain from:

- Internal assessment or data staff within your agency, if available
- Your Regional AIDSNET office
- The Department of Health, IDRH Assessment Unit, 360-236-3417.

Remember: All questions and focus group materials should be submitted to DOH prior to being implemented.

For more information on Gap Analysis or to receive a copy of the *Washington State HIV Prevention Planning Gap Analysis Model*, contract Nancy Hall at 360-236-3421.

Focus Group Format

Focus groups have four main stages; introduction; rapport building; in-depth discussion and closure.

The focus group facility should allow focus group participants to sit so they can see each other, such as a semi-circle or around a table.

- **Introduction**
  During the welcome it is important to discuss the purpose of focus group what will take place during the time the role of moderator/recorder, if there will be breaks, the ground rules and to obtain informed consent from participants.

  - **Purpose of the Focus Group**
    It is critical for participants to understand what their role is in the session and why the session is being held (i.e., to obtain information on MSM prevention needs). They need to know that their input will be valued and that their identity will be protected.

    It may be appropriate at this time to talk about confidentiality, use of data, and that you are interested in their perceptions and experiences. They do not need to feel that they are the resident experts in the community. These are all discussed in the Ground Rules section below.

  - **Moderator/Assistant's Role**
    All focus groups have a moderator, someone who will lead the group through a series of prepared questions. Many focus groups also use an assistant, someone who is in charge of the tape recorder and who records non-verbal group reactions to questions and comments (refer to Moderator and Assistant sections for more information).

    It is important for the participants to understand the role that each of these people will play during the focus group.

  - **Ground Rules: Setting the Tone**
    As with most trainings or workgroups, establishing ground rules can assist in making participants feel more comfortable. Important elements to include in your ground rules are described below.

    - Confidentiality
      Participants must be assured that information shared within the group should stay within the group. Information taken from the focus group will not be linked directly to particular participant(s).

      Hint: Participants should be identified by first name only. They may use pseudonyms. You may want to consider name tags or name tents.

- Use of the data
  It is important to go over the use of the data collected during the focus group.

- Respect for all viewpoints
  Participants need to be respectful of other's opinions and life experiences. There are no wrong answers.

- Speaking one at a time
  It is important that only one participant talk at a time. The purpose of the focus group is to gather information on experiences and perceptions. The moderator must be able to hear all responses. It is also important that all people get a chance to talk and that one person doesn't dominate the conversation.

- Importance of individual perspectives/openness
  You are asking them to provide their experiences and perspectives during the focus group, so there are no wrong answers. They do not need to feel like they are the resident experts for their community.

- Speaking about others' opinions/experiences
  During the focus group you may not only want to share your experience but know of others who have had different experiences that you may want to share. It is appropriate to share this information, but without the person's name.

  Hint: This also provides a chance for participants to share their own experiences but relate it to someone else, maintaining their confidentiality.

- Avoiding Meandering Conversations
  If the focus group conversation meanders off of the main topic, even as interesting as it may be, the moderator's role will be to refocus the discussion.

- **Informed Consent**
  Verbal consent **must be** obtained prior to starting the focus group. Verbal consent given by each of the participants is satisfactory. Attached is a sample verbal consent. Instructions for use are located in the Moderator Script, see *Focus Group Tools*.

- **Participant Introductions**
  Have the participants introduce themselves. Have them share one thing that they would like people to know about them. This may help in participants recognize their shared characteristics. Participants who share commonalities are more likely to be active participants.

Common moderator mistake:
At the end of the introduction, it is important to go forward into the rapport-building section. Many times moderators will pause and ask for any questions. This pause can take the control away from the moderator and pre-maturely start the discussion on the focus group topic.

- **Rapport-building**
  This is a bridging (takes people from one activity to another) activity that moves the participants towards the in-depth discussion stage of the focus group. It is designed to get participants talking and comfortable with each other. It can also serve as a way for participants to see the commonalities/diversities they bring to the discussion.

  Use easy, non-threatening questions to get people comfortable with talking in a group. The moderator may want to choose a topic that participants share. A well-designed rapport question can get participants talking and help identify the languages (terms) they use to describe their life experiences.

- **In-depth Discussion**
  This is the heart of the focus group. The in-depth discussion normally consists of a series of pre-determined open-ended questions presented by the moderator.

  - Focusing Tools
    Effective focus groups utilize a focus tool for participants. A focus tool used is to help participants come together on the particular focus group topic(s).
    This may be:

    - HIV/AIDS-related film directly pertaining to your topic
    - Brochure/Pamphlet
    - Story Board

  - Topic Guide
    The topic guide utilized by the moderator should include an introduction and a series of open-ended questions with prepared probing questions. Refer to *Developing Focus Group Questions* and *Approved Focus Group Questions* sections, for more information.

- **Conclusion**
  At the end of the allotted focus group time it is important to help participants wrap up their comments. In the conclusion it is important to:

  - Summarized similarities and differences heard in the group
  - Ask for additional input: "What did we miss?"
  - Thank participants for coming
  - Give incentives (if provided)

Using Incentives

Incentives are sometimes used in focus groups to motivate participation and to thank participants for their time. Participants who are motivated to attend are more likely to follow through on attending.

Incentives are often thought of as monetary but can be a variety of things such as store coupons or free movie passes. It may depend on your community's needs as to what your focus group participants may find as a desirable incentive.

It is unethical to mislead or coerce focus group participation. Incentives need to be comparable to the time invested by the participants, so that the incentive doesn't become the only reason attend. A half hour to an hour should be compensated with an incentive valued at $15 to $25.

Moderator Skill Needs

During the focus group the moderator has the most important and difficult job. The moderator should be a non-biased third party who is not already known to all the group members. A moderator should also have the skills to:

- Listen to participants,
- Pick up on subtleties; and
- Remember points to revisit during the session.

The moderator must also be skilled in group facilitation and presentation. Skills such as flexibility, humor and sincerity are characteristics linked to effective focus groups. It should also be someone who is not too close to the topic (e.g., the staff member who implements the group-level intervention you are conducting the focus group about).

Common Moderator's Mistakes:

- Talking too much, especially if there is a lull in the conversation;
- Providing their point of view;
- Feeling like they must advocate for the focus group topic; and,
- Using non-verbal body language (e.g., head nods, smiles signaling approval for a certain points of view. (Morgan, 1993). It may be helpful at the beginning of the focus group to tell participants that you may say "yes", "okay" or head nod in response to a participants' comments. Any "yes", "okay" or head nods are not a sign that you agree or disagree with the comments but, but actually affirming that you heard what they said.

Assistant's Role

The moderator's role is to be involved with the discussion of the focus group. It is very hard for them to keep on that task and also to remember all the important comments and information provided by the participants.

Most effective focus groups have a moderator and an assistant. The role of the assistant is to run the tape recorder and to capture verbal/non-verbal information from the participants during the in-depth discussion section.

Tape recorders can be a good tool to collect focus group information however, many times the tape recorder may not capture all of the participant's comments clearly. A reporter can capture many of these comments so that this important data is not lost.

It is important to let the group know that tape will not be made public.

Collecting and Analyzing the Data

It is important to consider how the data will be collected and analyzed during the PPNA focus group planning process, prior to the implementation of the focus group.

Questions to ask prior to starting your focus group:

- How will the data be utilized?
- Who will be responsible for collecting the data?
- Will the data be collected in a uniform manner?
- How will the data be analyzed?
- Where will the data be housed?

If you have people within your agency for data analysis, it may be useful to get their help in the planning stages of your needs assessment. Also may be able to assist in making sure the data collected will actually answer the questions you have for the target population(s).

Analyzing the Data
Analyzing qualitative data can be tricky. If you have not done this kind of analysis it is recommended that you seek assistance.

Points to remember when analyzing focus group data

- Look for the big ideas – trends or patterns in the information provided
- Look for commonalities and differences
- Consider the words, context which the word were stated in and specificity of the information provided
- Don't take a comment at face value – remember the context
- It is important to remember:
    - What was said
    - Who said it
    - How much was said about a specific issue
    - The order that things were said and,
    - The way things were said.

Ensuring Confidentiality

Data Collected
Any information collected during the PPNA process that personally identifies an individual (e.g., name, address etc.) is confidential information. It is best to use a system for separating data from the individual's demographic and locating information.

Eliminate any references to specific individuals in the transcripts (e.g., Dr. Smith to "my doctor"). Some places also will change the participants' names again in transcription to protect those who did not use fake first names in the original focus group.

Discussion of Data
Any discussion of data should not include use of specific participant's name or other information that may lead to identification of the participant. Some agencies also have their employees or the persons working on the needs assessments sign a confidentiality statement stating that they will not discuss information gathered.

Data Storage
After completion of the PPNA, all data collected (surveys, notes, cassette tapes etc) should be kept in a locked file cabinet. Only staff involved in the process should have access to the information. Once the data has been summarized and reported, source materials should be destroyed.

Every individual with access to confidential information must take personal responsibility for its protection. Community planning activities that collect information are bound by Washington State's confidentiality laws (RCW 70.24.105).

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Resources/References

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Good Questions Better Answers:
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California Department of Health Services Northern California Grantmakers AIDS Task Force. For copies call California AIDS Clearinghouse at (213) 845-4180.

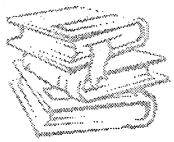
Morgan DL, Krueger RA, King JA (1998) *Focus Group Kit.* Sage publication: Thousand Oaks, CA.

This is a series of books that include:

- The Focus Group Guidebook
- Planning Focus Groups
- Developing Questions for Focus Groups
- Moderating Focus Groups
- Involving Community Members in Focus Groups
- Analyzing & Reporting Focus Results

Barbow RS, Kitzinger J. (1999) *Developing Focus Group Research: Politics, Theory and Practice.* Thousand Oaks: Sage Publications.

Morgan DL. (1993) *Successful Focus Groups: Advancing the State of the Art.* Thousand Oaks: Sage



Minnesota Comprehensive HIV Needs Assessment Plan 2000 – 2004;

Minnesota Department of Health AIDS/STD Prevention Services Section. December 1999. Minnesota Department of Health, P.O. Box 64975, St. Paul, MN, 55164-0975. (651)215-5800

In addition, assistance/guidance/information may be available from: Statewide Planning Group members, AIDSNET Coordinators, Department of Health staff, and/or staff at local health departments and community-based organizations.

FOCUS GROUP TOOLS

Focus Group Recruitment Questionnaire
Example

Date:_____ **Place:** _____

My name is _____ and I am working for _____. We are going to be bringing together people who _____(e.g., live in Yakima, are active injection drug users) for a small focus group (which is a group of people from similar backgrounds who are selected to provide feedback on a specific topic) to discuss their HIV prevention needs. Would you be interested in hearing more about this focus group?

We need to make sure that we have the right people at the table for the discussion, so I need to ask you a few questions.

1. Do you live here in this county/city?
   ☐ Yes ☐ No

2. How about we start with age. Are you in your 20s, 30s, 40s…..? _____

   [If the person is too young for your focus group, tell them that you are seeking persons within your prioritized population.]

3. How long have you lived in _____(city, county, state)? _____

4. This is a focus group about the HIV prevention needs of men who have sex with men and we want to talk to men who have had at least one male partner in the last 6 months.

   I need to know if this description fits you?

   ☐ Yes ☐ No, Stop and thank them for their time.

   NOTE: Put your basic criteria questions first (e.g., MSM who is over 18 and has lived in Seattle for over 6 months).

   If they meet your min. requirements you can go on with more specific information that you need to know in order to have diverse representation at your focus group.

   If yes, explain more about what you are doing.

Great, sounds like you are just the type of person we are looking for to participate in our focus group. We will be getting 8 to 10 people like you to meet to discuss HIV prevention needs and barriers. This information will assist the _____increase the effectiveness of their HIV prevention programs.

Two people from _____ will be actually leading the group(s). We will be asking for your perspectives and personal experience on HIV prevention. The meeting will last anywhere from a 1 to 2 hours and we will have lots of refreshments. Participation in this group is voluntary.

We will be tape recording the discussion so we don't lose anything, but anything you say will be kept confidential. In other words, we won't use your name in anything we do.

We also will be offering $25 for all persons who participate in the focus group, as a thank you for your time.

Are you still interested? If no, please tell us why. _____

For those still interested:

Okay, let me ask you a few more questions about yourself.

How about your education?
Did you finish high school? College?

_____ Less than high school
_____ High school graduate
_____ Some college (or technical)
_____ College graduate

5. What type of work do you typically do? _____

6. Have you worked/volunteered for the health department or other AIDS Service Organization?

☐ Yes: _____ ☐ No

Would you be available to attend a meeting, if it was held on Wednesday the 20th at 6:00 P.M. at the First United Church on Elm Street?

It is important that we have a commitment from you to attend this important meeting. If you are not able to attend, please call me directly at:_____ as soon as possible.

What questions do you have for me?

Recruited: ☐ Yes ☐ No
Recruited by: _____
Called for reminder: _____

Moderator Script
Focus Group Introduction Script

Welcome and thank you for taking time out of your busy schedule to discuss community need for HIV prevention. I'm _____, and I represent _____. My assistant is _____ from _____. S/he will be assisting to make sure that we capture all of your opinions and comments.

We have invited you all here today because you are all from the same community that we are interesting in working with and we want to learn more about your HIV prevention needs.

Today we will be asking you to discuss your experiences and perspectives during the focus group, so there are no wrong answers. We are not asking you to be the spokesperson for a particular group of people. We are interested in your perspectives and experience. We are interested in your positive and negative opinions, so please be as honest as possible. Also, we welcome you to bring in examples that friends or family may have experienced. However, we ask that you do not disclose whom you are talking about because they are not here.

Before we start, I would like to: 1) obtain verbal consent; 2) talk about some ground rules, for your participation and 3) discuss my role as moderator.

> *Hand out DOH approved informed consent form. Ask each participant to give verbal consent, one-by-one and then state for the record that all present have given consent for participation in the focus group. Do not have them sign and hand in consent forms. If they sign them, then they become confidential material and must be maintained confidentially.*

My role as your moderator is to ask questions related to HIV prevention and listen to your responses. I have a set of about 8-10 prioritized prepared questions for you. My role is not to participate in the conversation. If technical questions about HIV come up during the discussion, my role is not to provide education on HIV. After the focus group, I can give you a referral to answer questions on HIV.

It is important that only one participant talk at a time. The purpose of the focus group is to gather information on experiences and perceptions so I must be able to hear all responses. It is also important that all people get a chance to talk and that one person doesn't dominate the conversation.

If the focus group conversation meanders off of the main topic, even as interesting as it may be, my role will be to refocus the discussion.

At this point, what questions do you have about the ***focus group process*** for me?

HIV Prevention Focus Group Consent Form

Thank you for agreeing to participate in our needs assessment. We are trying to assess your or your communities' HIV Prevention needs to assist in determining program design and funding.

I understand that this focus group is for the purpose of increasing the effectiveness of HIV prevention services in Washington State.

I understand that during this focus group I will be asked questions about attitudes, knowledge, behavior and use of HIV prevention services.

I understand that the focus group will last 2 hours or less and will be audio taped and written notes may also be taken.

I understand that my participation in this focus group is voluntary and that if I wish to withdraw or to leave, I can do that at any time without explanation. If I do withdraw from the focus group, it will not affect my ability to obtain or continue with any agencies associated with the focus group activity.

I understand that information that I disclose here will be used to assist in increasing the effectiveness of HIV prevention programs. In this process, there could be a violation of my privacy. To prevent violations of my own or others' privacy, I have been asked not to talk about any of my own or others' private experience that I would consider too personal or revealing.

I understand that I have an obligation to respect other's privacy, keep things said here within the group and not disclose any personal information shared here with others outside the group.

I understand that all my information provided here today will be kept confidential in adherence with Washington State's confidentiality laws (RCW 70.24.105). No one other than authorized staff working directly with this project will have access to data provided by you during the course of the focus groups.

I understand that with the exclusion of a possible incentive that I will not directly benefit from this focus group but that my input may be helpful for designing HIV prevention programs that may benefit others.

The focus group moderator has offered to answer any question I have about my participation in the focus group and has explained what is expected of me today.

I have read and understand this information and I agree to take part in the focus group. *Note: Verbal consent must be given, at this time.*

If you have any concerns or questions about this focus group process, please contact the sponsoring agency: _____ at:_____.
You can also call the DSHS/DOH Human Research Review Board at (360) 902-8075.

Participant Demographics

We are collecting some basic demographic information about our focus group participants.

DO NOT PUT YOUR NAME ON THIS SHEET.

Ethnicity

Do you consider yourself Hispanic or Latino/a?

☐ Yes ☐ No

If yes, are you:
(Please circle only one response)

1. Puerto Rican
2. Mexican-American
3. American-Chicano
4. Mexican
5. Cuban
6. Central/South American
7. Dominican Republican
8. Other? (Please specify) _____

Gender/Age/Race

(Please place a check mark in the box that best describes you)

(M=males; F=females; T=transgender)	≤ 19 years old			20-29 years old			30+ years old		
	M	F	T	M	F	T	M	F	T
American/Indian/Alaska Native									
Asian									
Black or African American									
Native Hawaiian or Other Pacific Islander									
White									
More Than One Race									
TOTAL									

Education

In school, what is the highest grade you ever completed?
(Please circle only one response.)

1. Less than high school
2. High school graduate (including G.E.D)
3. Some College

4. College graduate
5. Post-graduate

County of Current Residence:

☐ Adams	☐ Douglas	☐ King	☐ Pacific	☐ Stevens
☐ Asotin	☐ Ferry	☐ Kitsap	☐ Pend Oreille	☐ Thurston
☐ Benton	☐ Franklin	☐ Kittitas	☐ Pierce	☐ Wahkiakum
☐ Chelan	☐ Garfield	☐ Klickitat	☐ San Juan	☐ Walla Walla
☐ Clallam	☐ Grant	☐ Lewis	☐ Snohomish	☐ Whatcom
☐ Clark	☐ Grays Harbor	☐ Lincoln	☐ Skagit	☐ Whitman
☐ Columbia	☐ Island	☐ Mason	☐ Skamania	☐ Yakima
☐ Cowlitz	☐ Jefferson	☐ Okanogan	☐ Spokane	☐ Don't Know

Example Questions for Prioritized Population's Needs Assessment

1. What is putting Population X at risk for HIV in our area (City, County, Region)?

Additional follow-up questions to ask:

- What are some risky things that prioritized population X do?
- Are prioritized population X drinking or doing drugs?
  - What are they using?
- What risky sexual activities are prioritized population X doing?
- Would you explain further, if you are comfortable?
- Could you give me some examples of what you mean?
- Tell me more about that?
- Do you think others feel the same way?
- What types of pressures do think population X is under to do risky behaviors?

Questions Appropriate about Prioritized Population's Barriers

1. Why do you think some people still practice risky/unsafe behaviors (sexual and injection drug use)?

- In general, how comfortable do you think people talking about sex/drug use?
- What about with their partners?
- Is there a difference between new and old partners?
- What types of situations would more likely put people at risk of practicing unsafe behavior?
  - Drinking
  - Don't have condom/clean needles
  - Poverty
  - Low reading level
  - Fear
  - Want to get pregnant
  - Don't care about themselves/others
  - Religious issues
- What are some things that get in the way of using condoms/clean needles/equipment?
- Tell me more about that.
- Give examples.
- How do you think others feel about this?

2. What are the environmental issues that make it difficult for people to lower their risk for getting HIV?

- Sociological, Financial

- Barriers to adopting safer behaviors
- Barriers to getting services
- Easy access to information, condoms, clean needles?
- Do you feel like you have to behave a certain way? Who makes it that way for you?

1. **Why types of HIV prevention messages have you heard?**

   - Have you felt that these messages were targeted for <u>population X's</u> needs?
   - What things make it work/not work?
   - What HIV programs would you be willing to participate if they were available?

2. **What are the elements in an HIV prevention program would be important to the targeted population?**

   - Individual sessions/activities?
   - Group session/activities?
   - Diverse activities?
   - Tell me more?
   - Types of materials?
   - Types of information?
   - Types of services?

3. **What is the best way to reach <u>Population X?</u>**

   - Where are they most comfortable talking?

4. **Who should deliver HIV prevention programs to <u>Population X?</u>**

   - Health Care professionals?
   - Outreach workers?
   - Trainer Peers?
   - Other, please explain?

ATTACHMENTS

Washington State HIV Prevention Planning Gap Analysis Model
Example Tables

PREVENTION NEEDS TABLE
Target Population: *MSM*
Prevention Need: *Knowledge*

		Worksheet A)	(Worksheet B			
Prevention Need Knowledge (MSM)	**How much of the target population possesses this information?**	**How do resources, services and policies outside of your direct control affect this need?**	**How do existing HIV resources currently address this need?**	**How would funding loss impact on this prevention need?**	**Is this an unmet need?**	**What is the priority of funding interventions based on this prevention need?**
1. HIV is a potentially life threatening disease	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical
Brief comments						
2. Knowledge of the behaviors that transmit HIV*	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical
Brief comments						
3. Knowledge of HIV status	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical
Brief comments						
4. Knowledge of HIV prevention**	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ None ☐ Little ☐ Some ☐ A lot ☐ Enough	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical	☐ Minimal ☐ Little ☐ Moderate ☐ Significant ☐ Critical
Brief comments						

ATTACHMENT 4

DRAFT WASHINGTON STATE EPIDEMIOLOGIC PROFILE (2002)

HIV/AIDS Epidemiologic Profile
Washington State – Update 2002
DRAFT – WORK IN PROGRESS

Purpose

The major objective of this HIV/AIDS epidemiologic profile is to provide community planning groups with a comprehensive understanding of the impact of HIV on Washington State. The profile should serve as a starting point in the development of a needs assessment and gap analysis that ultimately allows the community planning group to set priorities and make the best possible decisions for targeting HIV prevention activities. The data included in this report do not make the decisions; they are but one element in the decision making process. Epidemiologic data, knowledge of HIV prevention activities and their effectiveness, an understanding of the community, and knowledge of local values and beliefs are some of the factors that will be taken into account to make important decisions and develop a plan of action.

What's new?

In 2001, there was increased focus on the global epidemic. Around the world, 40 million people are estimated to be living with HIV/AIDS. HIV/AIDS is the leading cause of death in Africa and the 4th leading cause of death globally. The disease is a public health crisis and development crisis for many countries and has been recognized as a security threat by the United Nations, the United States, and other governments around the world. In April 2001, the U.N. General Assembly, under the leadership of U.N. Secretary Kofi Annan, convened a special session to mobilize resources to fight AIDS, tuberculosis, and malaria.

Nationally, there are a number of challenges facing the country, one being to maintain attention on the U.S. epidemic while responding to the global crisis. New data from the Centers for Disease Control and Prevention (CDC) suggest that the era of sharp declines in AIDS deaths and new AIDS diagnoses has come to an end. Reasons for this include reaching the limits of therapy in extending survival; failing therapies due to treatment-resistant viral strains; late HIV testing; inadequate access to and adherence to treatment in some populations; or recent increases in HIV incidence in some risk groups. An ambitious goal has been set to reduce the number of new HIV infections in the United States by half (40,000 to 20,000) by the year 2005. Other challenges include increasing the number of people with HIV/AIDS in care, addressing the disproportionate impact on racial and ethnic minorities, targeting at-risk populations and tailoring prevention interventions, integrating prevention and treatment, and reducing stigma.

Locally, Washington State has the advantage of now being able to incorporate data from HIV reporting into the epidemiologic profile to further describe the epidemic. As is the case nationally, declines in AIDS incidence and AIDS deaths appear to have leveled off.

While there have been shifts in the epidemic, there has also been continuing concern about the traditional risk populations. Although the proportion of Washington State AIDS cases attributable to men having sex with men has decreased over time, there is some evidence that this population may be experiencing a sexual safety relapse. Between 1997 and 2000, STD rates increased substantially among MSM in King County, and similar trends were seen in other cities in the U.S. and abroad. Increases in HIV seroprevalence have been seen in the King County STD clinic surveys, with a steady climb in seroprevalence from 4% in 1997 to 6% in 1998 to 11% in 1999. Studies also indicate increases in unprotected anal sex and in numbers of sex partners in MSM that are greater in younger men and men of color.

Demographic characteristics of Washington State

Table 1 presents some of the demographic characteristics of Washington State, including both the 1990 census figures and the 2000 census figures. Comparison of the distribution of the general population and the distribution of those with HIV/AIDS allows for identification of populations that are overrepresented in the epidemic.

Table 1. Characteristics of the Washington State population, 1990 and 2000

	1990 Census	2000 Census	
Total population, Washington State	4,866,692*	5,894,121**	
Gender			
Female	2,452,945 (50%)	2,959,821 (50%)	
Male	2,413,747 (50%)	2,934,300 (50%)	
Race/Ethnicity		Alone	Alone or in combo
White	4,411,525(91%)	4,821,823 (82%)	5,003,180 (85%)
Black	152,530 (3%)	190,267 (3%)	238,398 (4%)
Asian/Pacific Islander	215,411 (4%)	346,288 (6%)	438,502 (7%)
American Indian/Alaska Native	87,226 (2%)	93,301 (2%)	158,940 (3%)
Other	-	228,923 (4%)	287,400 (5%)
More than one race	-	213,519 (4%)	-
Hispanic ethnicity (any race)	214,489 (4%)	441,509 (8%)	
Age			
<=14	1,079,962 (22%)	1,255,051 (21%)	
15-19	325,081 (7%)	427,968 (7%)	
20-24	353,638 (7%)	390,185 (7%)	
25-29	411,518 (8%)	403,652 (7%)	
30-39	868,361 (18%)	921,428 (16%)	
40-49	657,140 (14%)	945,360 (16%)	
50+	1,170,992 (24%)	1,550,477 (26%)	

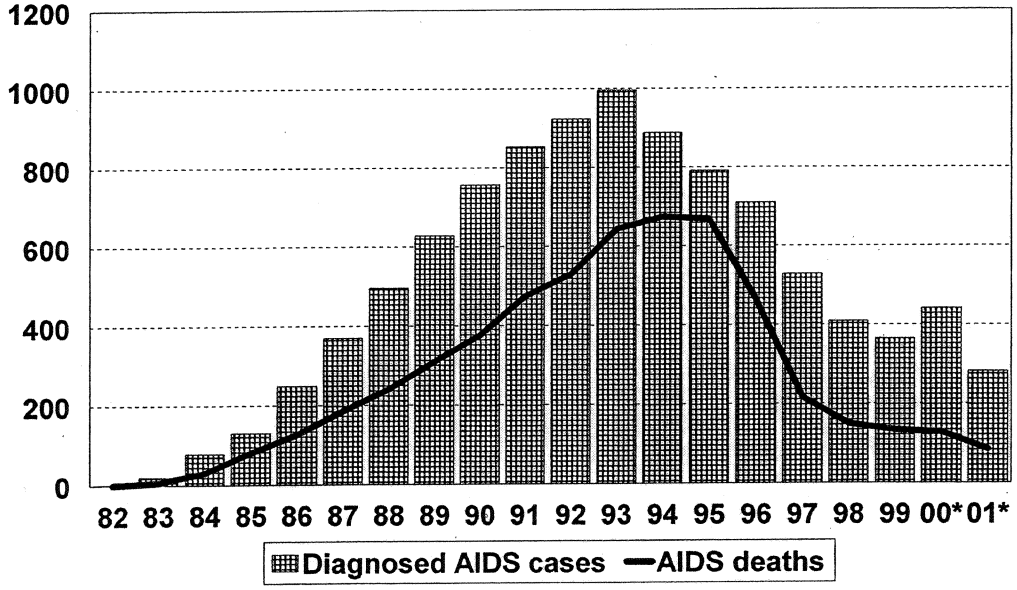
*Population Estimates and Projections: Department of Social and Health Services, Washington State Adjusted Population Estimates, April, 1999.
**U.S. Census Bureau, Profiles of General Demographic Characteristics, 2000 Census of Population and Housing, Washington State, May 2001.

QUESTION #1 - WHAT CHANGES HAVE WE SEEN OVER TIME IN AIDS CASES?

Trends in AIDS cases and deaths

Starting in the mid-1990s, AIDS incidence and mortality dropped precipitously across Washington State. **Figure 1** demonstrates the significant declines in AIDS incidence and deaths experienced by those diagnosed with AIDS and associated with use of highly active antiretroviral therapies. It also shows the "stalling" of these trends after 1998. AIDS case data are now more likely to describe those with inadequate access to care, those for whom the medications may not be working, those who are having problems adhering to medication regimens, and those who may have tested late for HIV.

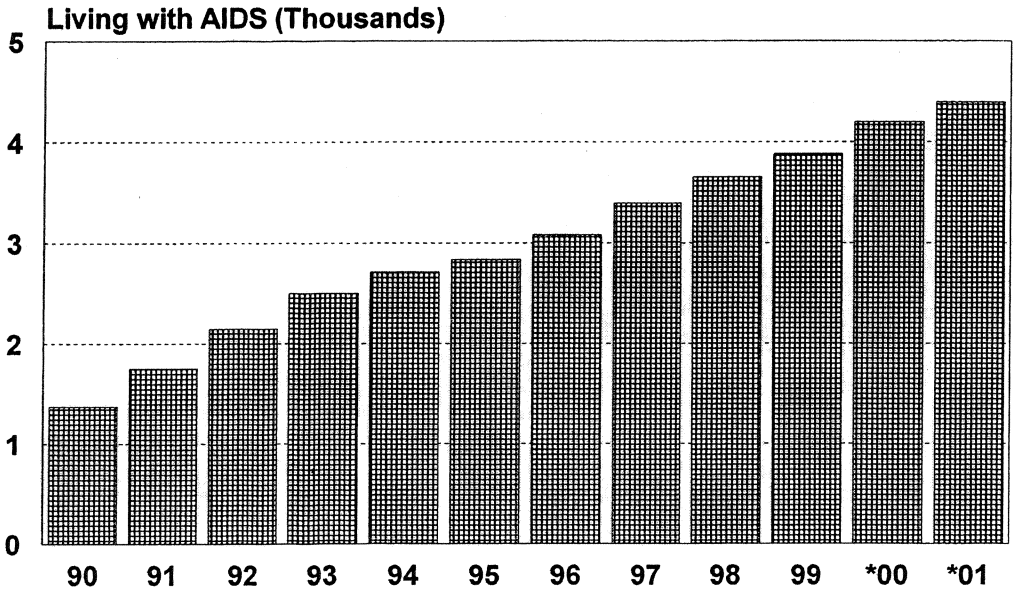
Figure 1. AIDS cases by year of diagnosis and AIDS deaths, Washington State, 1982 – 2001 (Note: Cases reported as of 12/31/01; reporting for 2000 and 2001 is still not considered to be complete*).



In 1999, HIV was the fifth leading cause of death among Washington men 35 to 44 years of age, accounting for 4% of deaths, and the sixth leading cause of death among men 25 to 34, accounting for 3% of deaths. Among women 25 to 34 years of age, HIV was the 6th leading cause of death, accounting for 3% of deaths.

The decline in HIV-related mortality has lead to an increase in AIDS prevalence. As can bee seen in **Figure 2**, the number of people living with AIDS in Washington State has been increasing, adding to the challenge of providing prevention and care services.

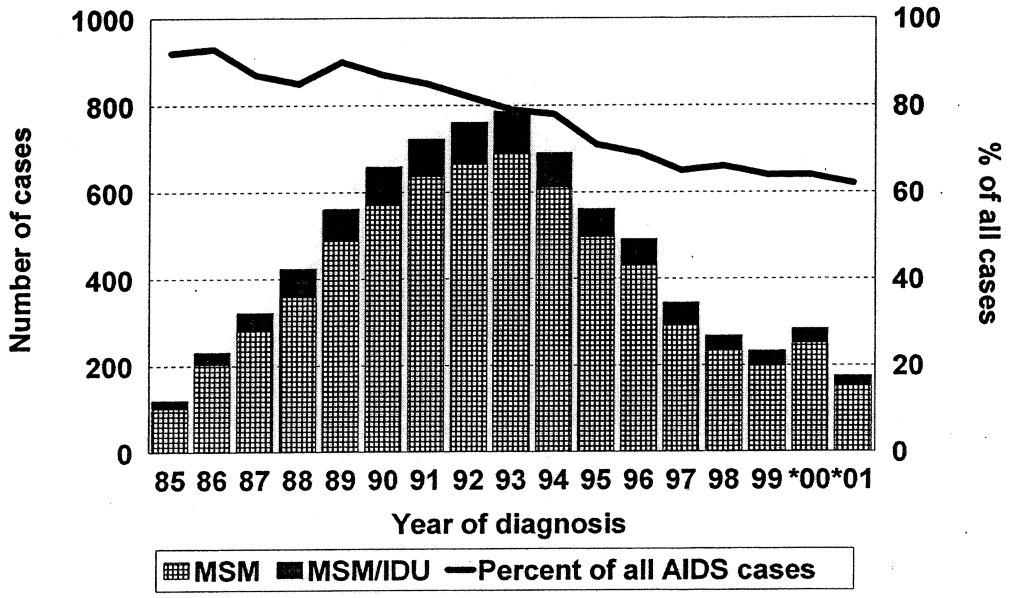
Figure 2. Number of people living with AIDS, Washington State (Note: Cases reported as of 12/31/01; reporting for 2000 and 2001 is still not considered to be complete.)



Trends in AIDS cases in behavioral risk groups

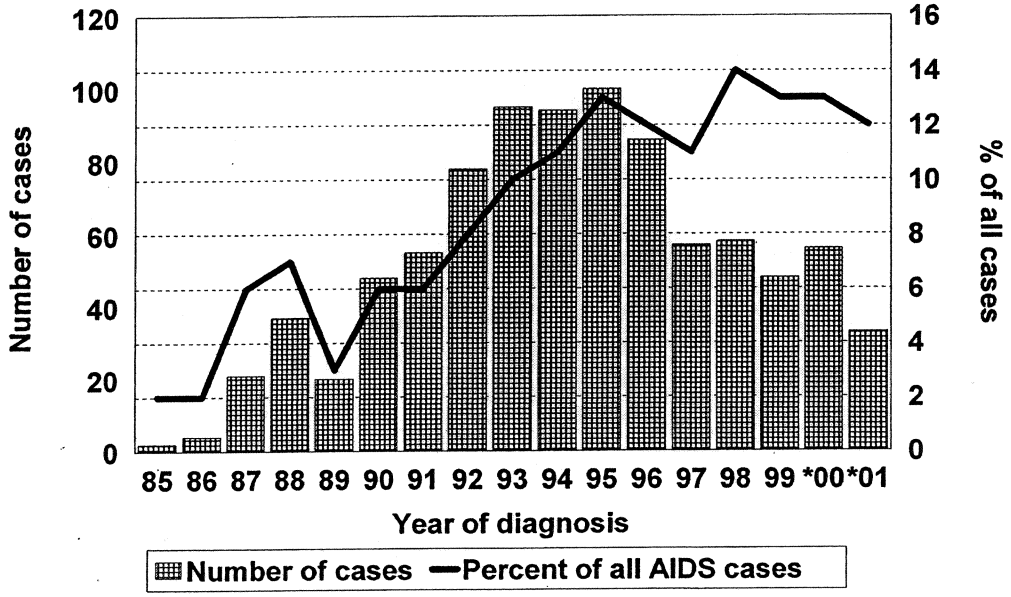
A. Cases due to men having sex with men (MSM) and men having sex with men and injecting drug (MSM/IDU)

Figure 3. Number of AIDS cases and proportion of all cases among MSM and MSM/IDU, by year of diagnosis, Washington State, 1985-2001. (Note: Cases reported as of 12/31/01; reporting for 2000 and 2001 is still not considered to be complete.)



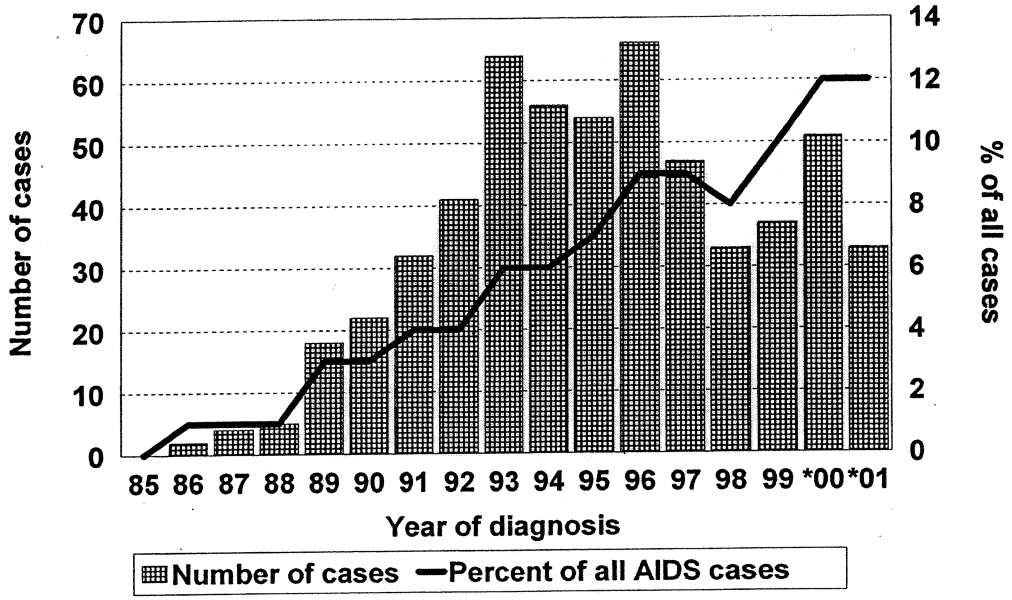
B. Cases due to injection drug use

Figure 4. Number of AIDS cases and proportion of all AIDS cases among female and heterosexual male IDUs, by year of diagnosis, Washington State, 1985-2001. (Note: Cases reported as of 12/31/01; reporting for 2000 and 2001 is not considered to be complete.)



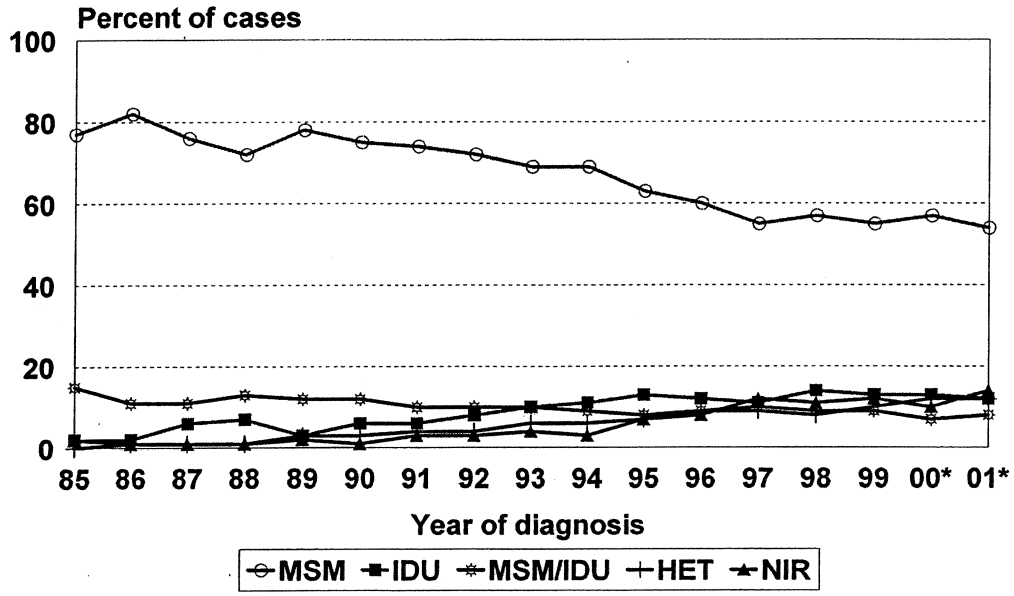
C. Cases due to heterosexual contact*

Figure 5. Number of AIDS cases and proportion of all AIDS cases among those exposed to HIV through heterosexual contact*, by year of diagnosis, Washington State, 1985-2001. (Note: Cases reported as of 12/31/01; reporting for 2000 and 2001 is not considered to be complete.)



*Heterosexual contact includes those infected through heterosexual sex with someone known to be HIV infected or someone at high risk for HIV infection (i.e., a bisexual male or injection drug user).

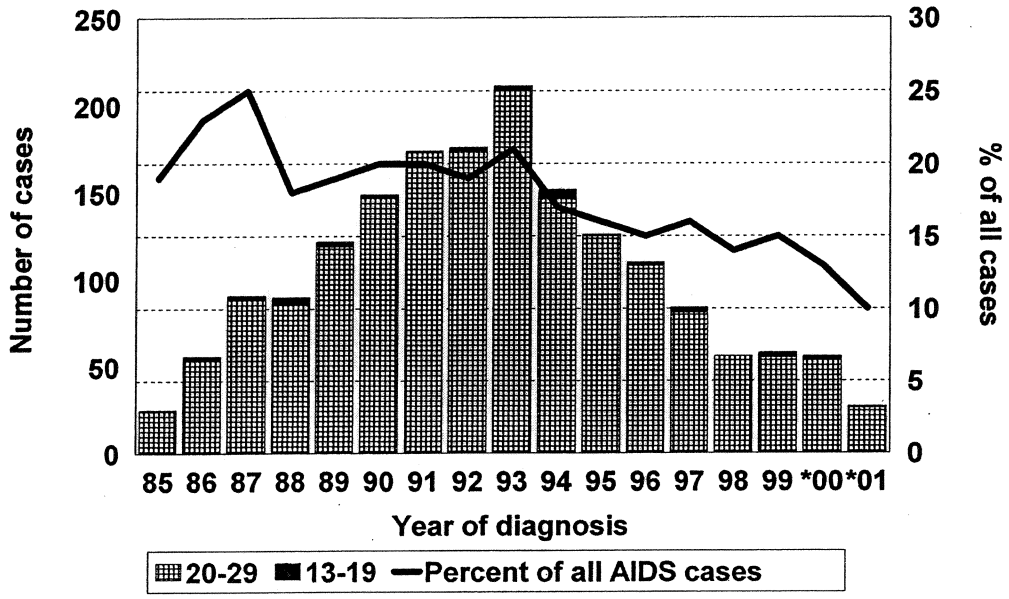
Figure 6. Proportion of AIDS cases accounted for by selected HIV exposure groups, Washington State, 1985-2001. (Note: Cases reported as of 12/31/01; reporting for 2000 and 2001 is still not considered to be complete*.)



The proportion of AIDS cases attributable to MSM has been decreasing in Washington State (**Figure 6**). The proportion of cases due to injection drug use has been increasing gradually over time, although the proportion seems to have stabilized in recent years. There has also been an increase in the proportion of cases due to heterosexual transmission. For recent years, the proportion of cases with no identified risk (NIR) is higher than previous years because those cases have yet to be investigated.

A. Cases in adolescents and young adults

Figure 7. AIDS cases among adolescents and young adults by year of diagnosis, Washington State, 1985-2001. (Cases reported as of 12/31/01; case reporting for 2000 and 2001 is still not considered to be complete*).



B. Cases in people of color

Figure 8. AIDS cases among people of color by year of diagnosis, Washington State, 1985-2001. (Cases reported as of 12/31/01; case reporting for 2000 and 2001 is still not considered to be complete*).

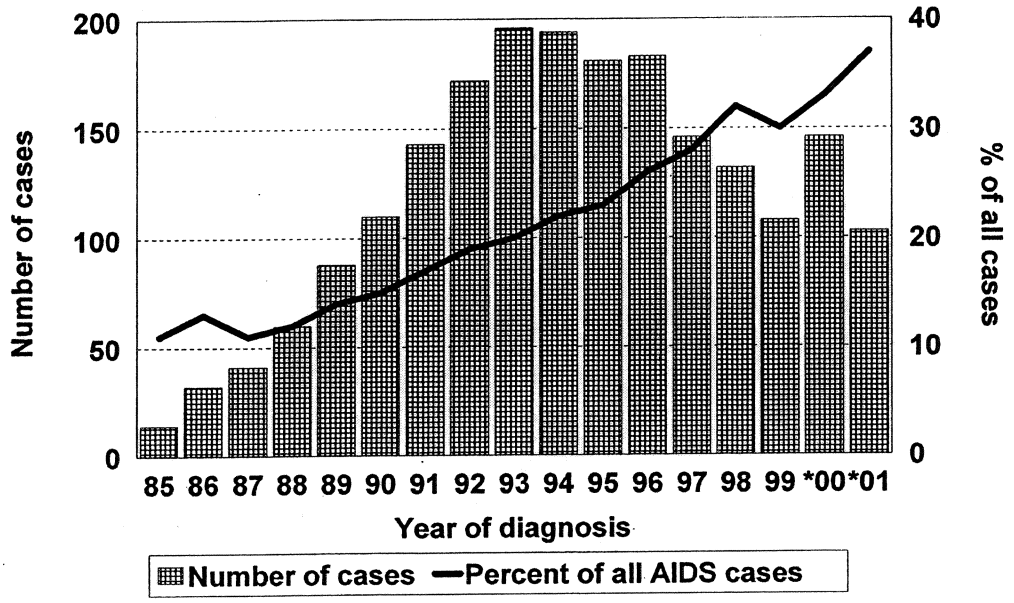
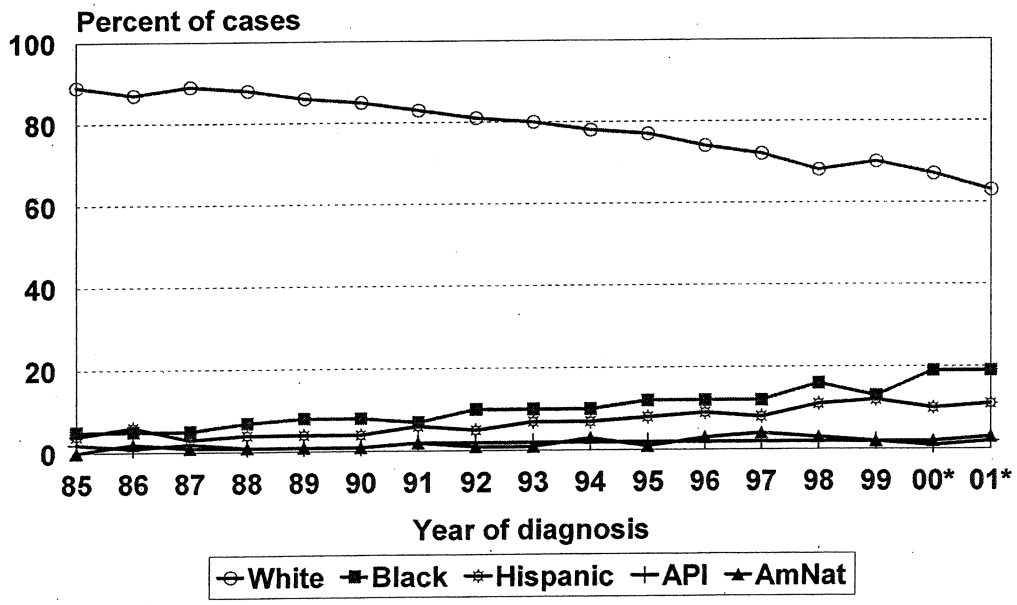


Figure 9. AIDS cases among people of color, Washington State, 1985-2001. (Cases reported as of December 31, 2001; case reporting for 2000 and 2001 is still not considered to be complete*.)



C. Cases in women

Figure 10. AIDS cases among women by year of diagnosis, Washington State, 1985-2001. (Cases reported as of 12/31/01; case reporting for 2000 and 2001 is still not considered to be complete).

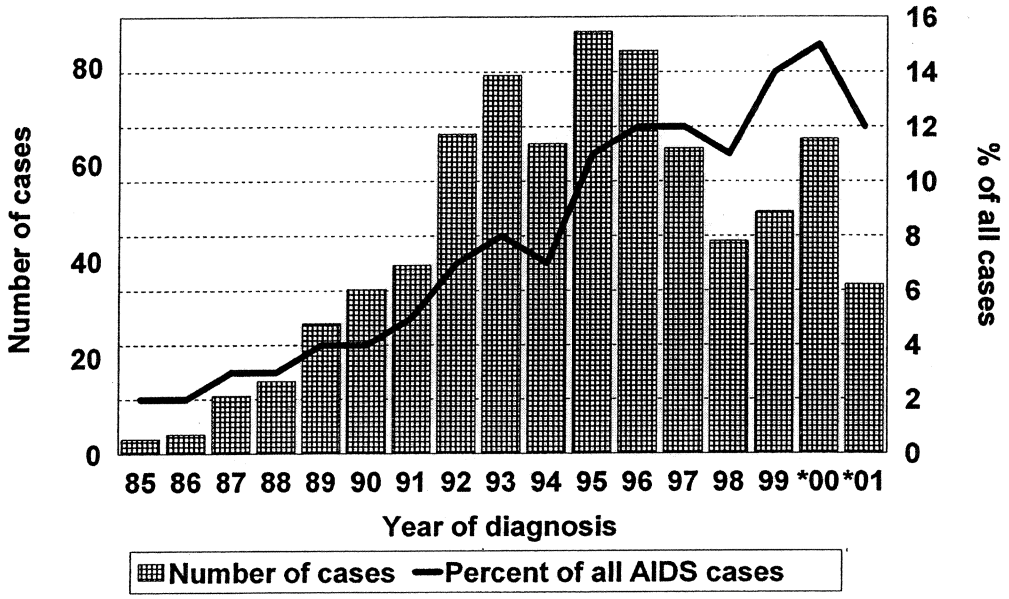


Table 2 describes the changes in the distribution of AIDS cases over time in Washington State. AIDS cases have included an increasing proportion of women, cases due to injection drug use and heterosexual transmission, and people of color, particularly Blacks and Hispanics. Additionally, the proportion of those diagnosed with AIDS who are over 40 years of age has been getting larger. This increase may be due, in part, to the ability of the new therapies to keep people from reaching an AIDS diagnosis until a later point in time.

Table 2. AIDS case trends over three time periods, Washington State

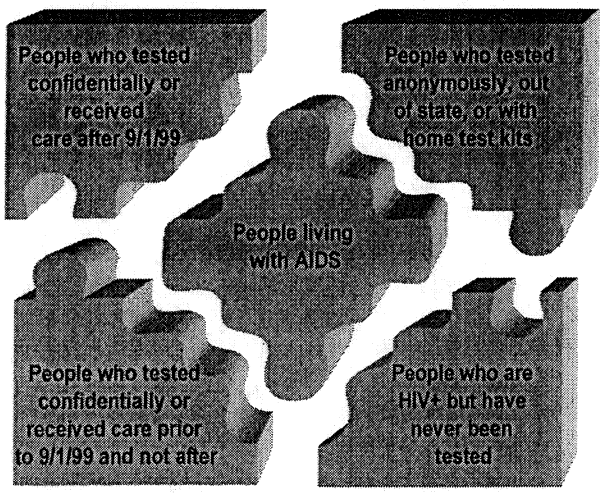
	Year of diagnosis			
	1982-1989 n = 1974	1990-1997 n = 6649	1998-2001* n = 1498	Cumulative N = 9921
AIDSNET region				
Region 1	80 (4%)	366 (6%)	96 (6%)	542 (5%)
Region 2	49 (2%)	201 (3%)	69 (5%)	319 (3%)
Region 3	113 (6%)	533 (8%)	120 (8%)	766 (8%)
Region 4	1448 (73%)	4107 (64%)	847 (57%)	6402 (65%)
Region 5	173 (9%)	674 (10%)	228 (15%)	1075 (11%)
Region 6	111 (6%)	568 (9%)	138 (9%)	817 (8%)
Gender				
Male	1910 (97%)	5935 (92%)	1304 (87%)	9149 (92%)
Female	64 (3%)	514 (8%)	194 (13%)	772 (8%)
Mode of exposure				
MSM	1518 (77%)	4393 (68%)	837 (56%)	6748 (68%)
IDU	85 (4%)	613 (10%)	195 (13%)	893 (9%)
MSM/IDU	235 (12%)	624 (10%)	123 (8%)	982 (10%)
Heterosexual contact*	29 (1%)	382 (6%)	154 (10%)	565 (6%)
Receipt of blood products	77 (4%)	119 (2%)	13 (<1%)	209 (2%)
Mother at risk for HIV	8 (<1%)	18 (<1%)	2 (<1%)	28 (<1%)
No identified risk/other	22 (1%)	300 (5%)	174 (12%)	496 (5%)
Race/Ethnicity				
White	1730 (88%)	5124 (79%)	1009 (67%)	7863 (79%)
Black	130 (7%)	641 (10%)	250 (17%)	1021 (10%)
Hispanic	77 (4%)	434 (7%)	163 (11%)	674 (7%)
Asian/Pacific Islander	24 (1%)	120 (2%)	29 (2%)	173 (2%)
American Indian/Alaska Native	13 (1%)	126 (2%)	38 (3%)	177 (2%)
Unknown	0 (0%)	4 (<1%)	9 (<1%)	13 (<1%)
Age				
<13	12 (1%)	18 (<1%)	2 (<1%)	32 (<1%)
13-19	12 (1%)	20 (<1%)	6 (<1%)	38 (<1%)
20-29	394 (20%)	1162 (18%)	191 (13%)	1747 (18%)
30-39	938 (48%)	3037 (47%)	664(44%)	4639 (47%)
40-49	422 (21%)	1633 (25%)	441 (29%)	2496 (15%)
50+	196 (10%)	579 (9%)	194 (13%)	969 (10%)

QUESTION #2 - WHAT DO WE KNOW FROM THE HIV SURVEILLANCE DATA?

HIV data

HIV data described in this profile include HIV cases reported to DOH through 12/31/2001. These data describe asymptomatic HIV cases reported as a result of the new reporting requirement as well as symptomatic cases, which have been reportable since 1987.

Figure 11. People living with HIV infection



Before considering the HIV data, it is important to understand both their strengths and limitations. HIV data generated by HIV infection reporting:

- Provide a *minimum estimate* of the number of HIV + persons in Washington State
- Describe those who are at an earlier point in their infection
- Do *not* effectively describe those who are newly infected (that is, do not give incidence information). The reporting system gathers data at whatever point in the

infection the person chooses to get tested, rather than the time of infection. Data represent infections from weeks to years old.

- Are not representative of all HIV-infected individuals. As can be seen in **Figure 11**, the universe of HIV-infected individuals is made up of a number of different groups, and information is available for some groups through the reporting system and not for others. For instance, for those who are HIV infected and have an AIDS diagnosis, information has been found to be >90% complete. For those who have been tested confidentially or received care after 9/1/99, when reporting went into effect, data are now available but still considered to be incomplete. There are people who know their HIV status because they tested anonymously, in another state, or with a test kit, and their information is not included in the reported statistics. There are people who know their HIV status because they tested or received care prior to 9/1/99 but not after, and their information is not available in the reporting system. Finally, there are those who have never been tested and are HIV-infected but do not know their status.

Additionally, there are many factors that influence testing and reporting patterns, such as access to medical care and the extent to which specific groups are targeted for testing.

Table 2. HIV infection (not AIDS) reported for Washington State (As of 12/31/2001)

AIDSNET region	HIV cases dx'd <98 N = 1,821	Recently dx'd 98-01 N = 1,131	All HIV cases N = 2,952
Region 1	74 (4%)	49 (4%)	123 (4%)
Region 2	49 (3%)	36 (3%)	85 (3%)
Region 3	155 (89%)	72 (6%)	227 (8%)
Region 4	1210 (66%)	782 (69%)	1992 (67%)
Region 5	206 (11%)	118 (10%)	324 (11%)
Region 6	127 (7%)	74 (7%)	201 (7%)
Gender			
Male	1554 (85%)	946 (84%)	2500 (85%)
Female	267 (15%)	185 (16%)	452 (15%)
Race/Ethnicity			
White	1433 (79%)	753 (67%)	2186 (74%)
Black	210 (12%)	203 (18%)	413 (14%)
Hispanic	103 (6%)	112 (10%)	215 (7%)
Asian/Pacific Islander	30 (2%)	35 (3%)	65 (2%)
American Indian/Alaska Native	33 (2%)	15 (1%)	48 (2%)
Unknown	12 (<1%)	13 (1%)	25 (1%)
Mode of exposure			
MSM	1129 (62%)	666 (59%)	1795 (61%)
IDU	196 (11%)	116 (10%)	312 (11%)
MSM/IDU	186 (10%)	75 (7%)	261 (9%)
Heterosexual contact*	137 (8%)	120 (11%)	257 (9%)
Receipt of blood products	19 (1%)	7 (<1%)	26 (<1%)
Mother at Risk for HIV	25 (1%)	5 (<1%)	30 (1%)
No Identified Risk/Other	129 (7%)	142 (13%)	271 (9%)
Age			
<13	27 (1%)	6 (1%)	33 (1%)
13-19	58 (3%)	28 (2%)	86 (3%)
20-29	712 (39%)	307 (27%)	1019 (35%)
30-39	708 (39%)	489 (43%)	1197 (41%)
40-49	249 (14%)	232 (21%)	481 (16%)
50+	67 (4%)	69 (6%)	136 (5%)

QUESTION #3 - HOW CAN WE DESCRIBE THOSE LIVING WITH HIV/AIDS TO BETTER MEET THEIR PREVENTION AND CARE NEEDS?

In all regions of Washington State, men who have sex with men (MSM) (including those who use injection drugs) comprise the majority of HIV/AIDS cases presumed to be living. (**Table 4**). In Washington State, 72% of those living with HIV/AIDS were men exposed through sex with other men. Note: Data that describe those living with AIDS rather than cumulative cases are used to provide insight on the impact of the epidemic in Washington State.

Because the HIV epidemic is really a series of epidemics occurring in different communities and populations (some of which overlap and some which don't), subgroups of the population should be examined to determine risk of HIV and trends over time. The following tables provide information on HIV exposure categories, gender, race/ethnicity, age at diagnosis, and region of residence for those living with HIV/AIDS who were diagnosed in Washington State.

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Table 5. Adults and adolescents living with HIV/AIDS, by HIV exposure category and sex, Washington State. (Cases reported as 12/31/01; case reporting for 2000 and 2001 is still not considered to be complete.)

HIV Exposure Category	Males	Females	Washington Total
Men who have sex with men (MSM)	4499 (71%)		4499 (63%)
Female and heterosexual male injection drug users	519 (8%)	252 (29%)	771 (11%)
MSM who use injection drugs	641 (10%)		641 (9%)
Heterosexual contacts*	194 (3%)	418 (48%)	612 (9%)
Receipt of blood products	64 (1%)	22 (3%)	86 (1%)
Other/unknown	405 (6%)	181 (21%)	586 (8%)
TOTAL	6322	873	7195

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Table 6. Adults and adolescent MALES living with HIV/AIDS, by exposure category and race/ethnicity, Washington State. (Cases reported as December 31, 2001; case reporting for 2000 and 2001 is still not considered to be complete).**

HIV Exposure Category	White	Black	Hispanics	Asian/Pacific Islanders	Amer.Ind. Alaska Nat.
Men who have sex with men	3684 (76%)	336 (49%)	328 (62%)	87 (76%)	49 (47%)
Heterosexual male injection drug users	328 (7%)	104 (15%)	62 (12%)	6 (5%)	18 (17%)
MSM who use injection drugs	512 (11%)	54 (8%)	39 (7%)	4 (3%)	30 (29%)
Heterosexual contacts*	79 (2%)	79 (12%)	26 (5%)	5 (4%)	4 (4%)
Sex with IDU	*29*	*8*	*10*	*1*	*1*
Sex with blood recipient	*2*	*0*	*0*	*0*	*0*
Sex with HIV+/AIDS	*48*	*71*	*16*	*4*	*3*
Receipt of blood products	54 (1%)	1 (<1%)	7 (1%)	1 (<1%)	0 (0%)
Other/unknown	212 (4%)	108 (16%)	63 (12%)	12 (10%)	3 (3%)
TOTAL	4869	682	525	115	104

*Heterosexual contacts of a person known to have HIV or be at risk for HIV. **Includes 27 people of unknown race/ethnicity.

Figure 12. Case rates per 100,000 population for MALES living with HIV/AIDS in Washington State. (Cases reported as of 12/31/01; case reporting for 2000 and 2001 is still not considered to be complete.)

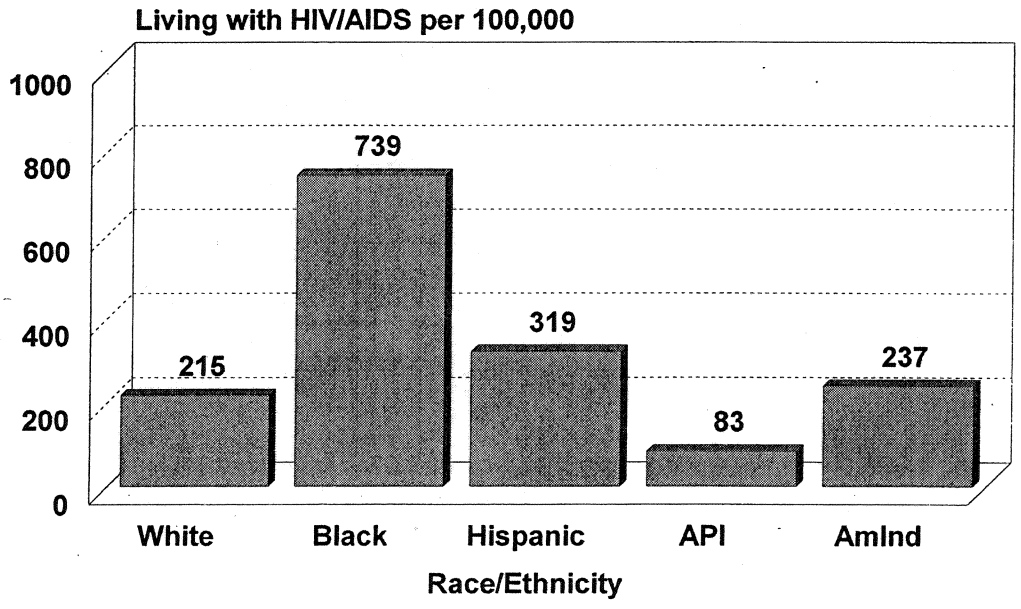
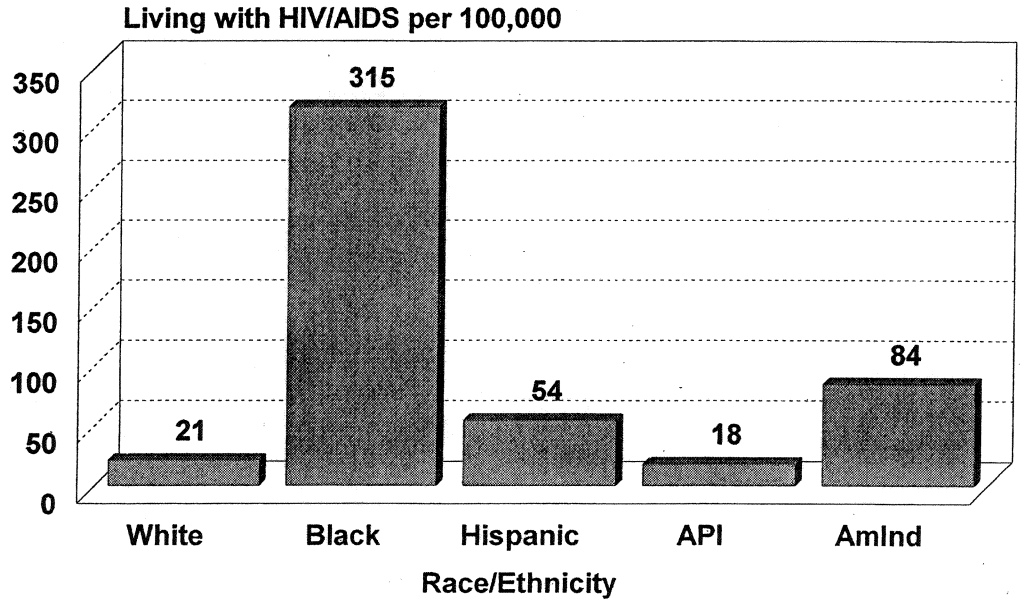


Table 7. Adults and adolescent FEMALES living with HIV/AIDS, by exposure category and race/ethnicity, Washington State. (Cases reported as December 31, 2001; case reporting for 2000 and 2001 is still not considered to be complete).**

HIV Exposure Category	White	Black	Hispanics	Asian/Pacific Islanders	Amer.Ind. Alaska Nat.
Men who have sex with men					
Female and heterosexual male injection drug users	156 (33%)	61 (24%)	11 (14%)	1 (4%)	23 (62%)
MSM who use injection drugs					
Heterosexual contacts*	227 (48%)	116 (46%)	51 (66%)	13 (48%)	8 (22%)
Sex with bisexual male	*26*	*5*	*3*	*0*	*1*
Sex with IDU	*76*	*29*	*11*	*0*	*3*
Sex with blood recipient	*9*	*2*	*0*	*1*	*0*
Sex with HIV+/AIDS	*116*	*80*	*37*	*12*	*4*
Receipt of blood products	9 (2%)	9(4%)	1 (1%)	3 (11%)	0 (0%)
Other/unknown	81 (17%)	68 (27%)	14 (18%)	10 (37%)	6 (16%)
TOTAL	473	254	77	27	37

*Heterosexual contacts of a person known to have HIV or be at risk for HIV. **Includes five people of unknown race/ethnicity.

Figure 13. Case rates per 100,000 population for FEMALES living with HIV/AIDS in Washington State. (Cases reported as of 12/31/01; case reporting for 2000 and 2001 is still not considered to be complete.)



ATTACHMENT 5

REGIONAL PLAN PROGRESS REPORTS (2002)

ATTACHMENT 5
REGIONAL PLAN PROGRESS REPORTS (2002)

REGION 1

Calendar year 2002 represents year 3 in the RPG's three year planning process. With conclusion of 2002 the RPG will embark on another multi-year planning process. This process has proven to be much more effective than single year planning and has reflected a much more efficient use of the RPG's planning time and efforts.

The planning process itself has been very successful this year. Seven meetings are scheduled during 2002. Five have been completed prior to submission of this comprehensive plan. More than 20 members have participated in each of the five planning meetings completed to date. Results of analysis of meeting evaluations show that members find the process to be meaningful. The PIR plan is being implemented effectively, and members are making more informed decisions relative to the RPG's work.

The Epi Profile update for 2002 was reviewed following presentation by DOH, and findings from the profile incorporated in the RPG's prioritization of high-risk categories and subcategories. While member experience continues to play into decision-making processes, it is increasingly apparent that a growing number of members recognize the importance in making decisions that are guided by data and scientific findings.

Prevention intervention plans have been developed and refined on an annual basis, with input from both DOH and the AIDSNET Coordinator. Tighter construction of interventions using more realistic and specific target categories/subcategories/populations and developing each intervention to assure accountability proved to be effective. Data and information extracted from the SHARE system enable the AIDSNET Coordinator to monitor and work closely with intervention providers to improve their prevention efforts that target high risk categories and subcategories prioritized by the RPG. The DOH representative to the RPG (Frank Hayes) provided valuable TA.

The Subcommittee and ad hoc committee structure of the RPG continues to serve a vital function in the planning process. The Membership subcommittee has been instrumental in developing and implementing the PIR plan, in identifying high risk populations and others who are underrepresented on the RPG, and in providing the guidance for the RPG members to bring to the planning table individuals who represent those who are underrepresented. This year, the Membership subcommittee has highlighted the importance of confidentiality in the planning process, developing confidentiality statements for members and for others who are present at meetings. The Prioritization Ad Hoc Committee worked persistently through the latter half of 2001 and the first half of 2002 to arrive at a short prioritized list of high risk categories and subcategories that represent the region and that were endorsed by the RPG at its June 12, 2002 meeting.

Additional examples of what worked include the following:

- The addition of orientations for new members, and the retention of current knowledgeable members, resulted in a maturing of the RPG. This year there were a notable reduction in the amount of bickering and an increase in selfless consideration of planning activities and interventions.

- Regular, frequent updates from the RPG members who also serve on the State Planning Group (SPG), and from those who serve on RPG subcommittees and ad hoc committees, resulted in a better informed RPG.

- The RPG Co-Chairs conducted tighter meetings minimizing the opportunity for discussions to wander. They also gave greater consideration for new members when discussing and presenting information by providing a list of acronyms and by explaining acronyms that were used in discussion. The streamlined discussion process resulted in a reduction in the number of attempts by individuals to dominate and to have undue influence on the discussion and decisions.

- Disclosure of a conflict of interest by individuals or by other members when discussing specific programs or issues related to funding, appeared to result in a less biased, more open and effective planning process.

The expectations of CDC and DOH relative to the community planning process, and the limited resources available to act on these expectations, pose the greatest difficulty faced by the RPG. Five areas have been identified earlier in this document that are to be addressed by the RPG in its next multi-year planning process: Gap analysis/Needs assessment; Targeted Population Assessment; Cost analysis; Outcome evaluation; Prioritization of effective interventions, among others (e.g., CRI). These expectations are admirable and the RPG takes seriously its work relative to HIV prevention, but in an atmosphere of budget reductions, and working with a budget that presents limitations before accounting for the reductions, members experience disappointment and frustration knowing that their efforts are essentially "scratching the surface" of what should be done in an ideal context.

Clearly, the need for technical assistance is apparent if the RPG is to successfully implement the activities necessary to address these key areas that will become the focus of the RPG's activity during the next multi-year planning cycle. Technical assistance, together with funding assistance, will be critical to the success of these planning efforts. Therefore, the RPG has submitted the request for this assistance in this document.

Indicate the successful prevention efforts in the region and areas of concern? Were these concerns addressed in the Prevention Plan?

There are a number of successful prevention efforts in the region. Notable among these are:

- The Know Your Status program, implemented this year, that addresses the RPG's number one prioritized high risk category: HIV+ and/or their partners.

- The ROPED program which has been successful at delivering prevention efforts on the Colville and Spokane Indian Reservations. Indeed, one result of this success is reflected in the fact that the Tribal Councils of both the Colvilles and the Spokanes endorsed the application submitted by SRHD to implement the MANITO program targeting American Indians and Alaska Natives who reside on either reservation or in Spokane County.

- The Prevention Plus Program has expanded to delivering needle exchange services in Whitman County, addressing an identified high risk need in that area.

Areas of concern are presented above and relate primarily to the key areas that the planning group is to address while the level of funding and the availability of resources diminishes. How to engage in a comprehensive Gap analysis/Needs assessment, Outcome evaluation, Cost analysis, etc. and to do this well, is the principal

REGION 2

In 2003, the following "Interventions in a Box" will be used in all Region II counties. These interventions will be used to target Region II sub-populations for both MSM and IDU.

The interventions below are those that are used for the target risk categories and priority populations for FY 2003. These are the Interventions in a Box that can be adapted for use in the region.

- Hot, Healthy and Keeping it Up
  Small group education for MSM and Hispanic Non-Identifying MSM*Wendy – they DO identify as Hispanic, but not as MSM
- Let's Chat
  Small group (intensive single session) for Jails, DH, and Drug Tx centers not able to provide time for multiple sessions
- Project Smart
  Small group for IDUs or Drug Tx centers that will provide time for multiple sessions
- Doing Something Different
  Small group for STD or Jail Clinic setting

Indicate the successful prevention efforts in the region and areas of concern?

- In 2002 two pilot projects were started in Yakima County for use of 'Behavior Change Education' in small groups for Migrant Seasonal Farmworkers and Needle Exchange clients. The small groups consisted of 6-9 individuals for three sessions. Through the Yakima Needle Exchange, small groups were formed, providing harm reduction behavior change education. Incentives were used to encourage attendance at all sessions. Attendance after the first session was amazing and encouraging for staff. Out 11 small groups

with a total of 86 attendees, only 2 individuals did not complete the all three sessions. The incentive was money (total of $30.00), if all sessions were completed. Food was provided as well, and many participants stated that they had not eaten in a couple days. The small groups for the at-risk Migrant/Hispanic Farmworker were equally successful. In all 13 small groups of 8-10 individual were completed Again, incentives of food were used, as many of the groups took place in the evening around 7:30 p.m. Many participants were attending after working in the fields for 12-14 hours. The Migrant/Hispanic groups were established through Outreach staff working with one or two individuals in each camp to set up groups. Once word of the groups spread through the Migrant camps, others would want to join which allowed for new groups to be established. By the end of the three sessions, most identified as having engaged in MSM activities, but would not identify as Gay or Homosexual.

- "Know Your Status Project" is a collaborative effort between Region I, Region II and DOH. KYS will work to identify those at risk, to help identify others that are also engaging in high-risk behaviors. Those meeting the qualifications of the program will be paid a fee for being tested for HIV.

- BI-Regional Coordination and Outreach activates with Region I

- Coordinated support and linkage with KDNA a Spanish language radio with HIV/AIDS PSAs, live radio call-in shows, and coordinated PSAs with Outreach efforts for Migrant/Hispanic populations.

- In 2002, an immunization program for hepatitis A and B, was offered through the Yakima Needle Exchange for Needle Exchange clients and their partners.

- TB screening, testing and medication, if needed, is available through Needle Exchange

- Over the past few months, Yakima has experienced 6 deaths related to Black Tar Heroin use. Prior to many of these deaths, individuals were transported to Seattle for medical treatment, over three hours away. The Yakima Needle Exchange staff has also seen a dramatic increase in clients with severe abscesses. While clients are referred to medical care, many refuse to go; out of fear regarding the care and treatment they will receive because of their known or suspected drug use. In 2003, the Regional office will work with the U. of Washington School of Medicine Family Practice Residency Program, in Yakima, to provide onsite medical

assistance to needle exchange clients. While there are many issues and concerns surrounding this, it is hoped that a new sense of trust may be built between the IDU and Medical communities.

Were these concerns addressed in the Prevention Plan?

Barriers for Region II Prevention

- Lack of specific data on Hispanic Migrant Seasonal Farmworkers.
- Lack of medical care for abscess for IDU
- Reduction of State funding for prevention activities for 2002 and additional reduction for 2003.

REGION 3

This is the first year of a new three-year planning cycle. As such, the elements of the planning process are scheduled over this and the following two years. Progress on this plan will be reported in 2003 and 2004. What has been accomplished to date in this planning year is described in the Executive Summary. It should be noted that some of the elements are similar to what was done in previous years and previous planning cycles, e.g., membership recruitment and selection, planning evaluations, prioritization of risk populations. These are each described in this document. Region 3 HIV/AIDS Community Planning Council received some technical assistance from the Washington State Department of Health staff for the Epidemiologic Profile, and for a new process of prioritizing risk populations and sub-populations

REGION 4

We have substantially increased and diversified membership on the committee, and have been focusing on training committee members to be strong planners and to balance advocacy and planning roles. We completed the bi-annual prioritization process and allocated over three million dollars in accordance with our prioritization plan. We are currently working on planning our 2003 prioritization process, expanding committee membership and doing target population assessments. We continued work on bridging prevention and care services by providing the training series at the end of 2001, and working in committee.

REGION 5 – Kitsap County

The 2002 plan was implemented January 1, 2002. Two changes took place mid-year.

- First, a local provider has started a GLBTQ youth group. The contract with Pierce County AIDS Foundation OASIS Program was cancelled effective June 30, 2002. A new intervention plan has been written for the Kitsap County Program. It is enclosed.
- Second, the local Board of Health approved a syringe exchange. A contract is prepared for signature by an existing Puget Sound Needle Exchange Program. They will provide services in Kitsap County. The intervention is attached. This decision has enabled the SAK intervention to evolve from a "pay the actual cost" of the

syringe to an exchange. Thus, the Health District will continue to serve IDUs with a more accessible syringe exchange in addition to the street outreach needle exchange.

REGION 5 – Pierce County

One of the most significant accomplishments for this planning cycle, is the completion of a combined regional three-year plan. This combined three-year plan will allow both planning groups time to evaluate the plan and the process. Until this year, both groups were continuously in a planning mode and could not evaluate what had been accomplished. Therefore, a thoughtful evaluation of the implementation of the previous year's plan will occur and be reported in year 2003.

REGION 6

The previous year's plan was a "2002 Update" to the Region 6 AIDS Network 2002-2003 HIV Prevention Plan. 2002 the regional Planning Committee made further progress in implementing by the Ellensburg Document" by 1) using the planning guidance developed by the State Planning Group (SPG), and 2) ensuring that 100% of CDC funds and at least 50% of state AIDS Omnibus funds will be used to respond to priorities in the Region 6 HIV Prevention Plan.

To address these requirements, the Region 6 AIDS Network staff worked with each local subcontractor agency to use at least 50% of AIDS Omnibus funding to implement effective interventions that address regional priorities. Procedures were followed requiring that all subcontractors bill Region 6 by intervention and to enter data in a timely way into the Statewide HIV Activity Reporting and Evaluation (SHARE) system. Providers also were paid on a cost reimbursement basis.

The Region 6 support program completed a significant transition, moving its office from Olympia to Vancouver, and reconstituting its entire staff. The intent of these actions were to improve regional services by recruiting highly qualified staff, and reducing costs as much as possible.

An area of concern arose when a local health jurisdiction that was selected to implement a significant intervention to MSM chose not to carry out the project. The regional Planning Committee will work to implement an alternative high-risk intervention during the remainder of 2002.

New MSM interventions were implemented in 2002 in Thurston, Clark, and Lewis Counties. The region was able to target more ethnic minority populations with interventions, and programs to meet the prevention needs of high-risk youth are now available in six counties of Region 6. One jurisdiction developed a syringe exchange intervention to combine provision of hepatitis vaccines and screenings and counseling and testing services with exchange services. Another jurisdiction is also considering adopting this approach.

ATTACHMENT 6

2002-2003 WASHINGTON STATE HIV PREVENTION PLAN

(September 2001)

Plus

ATTACHMENTS

ATTACHMENT 6
2002-2003 WASHINGTON STATE HIV PREVENTION PLAN

The 2002-2003 Washington State HIV Prevention Plan was distributed in a PDF/CD Rom format and is found on the second disk of this set of 2.

The 2002-2003 Plan and the 2003 Update are also available on the web at:

www.doh.wa.gov/cfh/hiv.htm

If you have questions on concerns about this state plan or update, please feel free to contact Nancy Hall, Washington State Department of Health, HIV Prevention and Education Services at (360) 236-3421 or nancy.hall@doh.wa.gov